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PURPOSE

The purpose of this Association shall be to bring into close contact by association and communication lawyers, barristers and solicitors who are residents of the United States of America or of any of its possessions or of any country in the Western Hemisphere, who are actively engaged wholly or partly in the practice of that branch of the law pertaining to the business of insurance in any of its phases or to Insurance Companies; to promote efficiency in that particular branch of the legal profession, and to better protect and promote the interest of Insurance Companies authorized to do business in the United States of America or in any country in the Western Hemisphere; and to encourage cordial intercourse among such lawyers, barristers and solicitors, and between them and Insurance Companies generally.

President's Page

THIS issue of the Journal, inaugurating its twenty-eighth year of publication, comes to you with a "new look"—specifically a new cover and a different style of table of contents. The Editorial Staff has developed these modifications to make the Journal more interesting and more "eye-appealing." The articles in this issue are especially practical and useful. You will find the Journal increasingly valuable in your work, and I urge you to contribute the results of your experience and research in the form of articles that may be published in future issues for the benefit of your fellow lawyers and the courts.

What is now the Defense Research Committee was created in 1952 to seek, among other objectives, ways and means of bettering the then rapidly deteriorating situation of the American tort loss payer. Into the work of that Committee have gone, through the years, thousands of man hours of effort on the part of IAIC members throughout the country. A halt must be called on those who endeavor to propagate throughout the country the "Hollywood type of trial."

University of Michigan researchers report in the August, 1960 issue of the Michigan State Bar Journal that in a recent year the nation spent almost $4,000,000,000 in compensating personal injury damage claimants, a sum about equal the amount spent for all highway construction by local, state and federal governments combined, and twice the amount received by farmers for the value of their food grain production. Of the "injury industry," these researchers say that it is "*** surprising *** that so little is known about so large an economic activity."

The studies conducted by the Defense Research Committee long since convinced thoughtful IAIC members that it is no longer enough for us simply to do a good job in court on each and every case entrusted to us. Today's personal injury plaintiff may be tomorrow's defendant. In either capacity, he is entitled to a fair and impartial trial, no more and no less. Defense lawyers must make an organized effort to safeguard and perpetuate this kind of trial.

The Institute has the enthusiastic support of defense lawyers throughout the country. It has now employed a General Manager and opened an office in Syracuse, New York, and will soon select an Executive Director. The Institute has taken over the publication of FOR THE DEFENSE.

Each and every IAIC member is entitled to become and should become an Associate Member of the Institute. Others engaged in defense trials and claims administration may become Sustaining Members. Law firms engaged in defense practice are solicited to become Sponsors on a single contribution basis.

DENMAN MOODY
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CURRENT DECISIONS

Recent decisions of the courts dealing with insurance and negligence law and practice are included in these pages. Journal readers are asked to send in digests of such rulings. Unreported cases dealing with novel questions are especially desired. Members of I.A.I.C. should submit their contributions to their State Editors.

Edited by
R. HARVEY CHAPPELL, JR.
Richmond, Virginia

ACCIDENT INSURANCE– OFFICERS' COVERAGE DOES NOT EXTEND TO OFFICERS-ELECT

Rachford v. Indemnity Insurance Co. of North America, 183 F. Supp. 875 (S.D. Cal., 1960).

Decedent's executor brought suit against accident insurer seeking recovery under policy issued by the insurer covering the "officers and employees of the National Education Association and its departments." The decedent was a director of audio-visual instruction for the Los Angeles county schools and in October, 1957, she was one of three persons nominated for the office of vice-president of the department of Audio-visual Instruction, an autonomous organization within the general framework of the N.E.A., and in the December, 1957, election, she was duly elected. Under the bylaws of the organization, newly elected officers would take office at the close of the annual winter meeting which was not held until after April 21, 1958. On April 21, 1958, while en route to Minneapolis to be installed as vice-president and to attend a meeting of the board of directors as an observer prior to her installation, the decedent was killed in a crash of an airplane. The United States District Court entered judgment for the defendant insurer applying the general rule that in construing a contract, language is to be given its ordinary meaning and that the court could not rewrite an insurance contract. The word "officer" within a group accident policy covering officers of an association, does not include a person who has been elected to office but who has not yet been inducted into office.

AUTOMOBILE INSURANCE– COOPERATION CLAUSE

Standard Mutual Insurance Company v. Kinsolving, 167 N.E. 2d 241, (Ill., 1960)

Insured was a passenger in the insured automobile at the time of the accident, the automobile then being driven by another party. The insurer was notified of the accident and immediately commenced investigation of the case. Insurer received a written statement from the insured stating that he was the driver of the automobile at the time of the accident and accident reports to the same effect were filed. The insurer also received a statement from another passenger in the automobile stating that the insured was the driver and, later, such passenger brought suit against the insured based on his having been the driver of the automobile. During the taking of discovery depositions it developed that the insured was not the driver and that the information previously supplied had been false. Thereafter, the instant action for a declaratory judgment was instituted and judgment was entered for the insurer. On appeal, the appellate court of Illinois affirmed the action of the lower court holding that the policy conditions concerning notice, assistance and cooperation had been violated. The court held that an insurance policy is a contract and in this instance the insured had breached that contract. See *Ciaccio v. Norfolk and Dedham Mutual Fire Co.*, 158 A. 2d 277 (R.I., 1960), discussed in 27 Insurance Counsel Journal 509 (October, 1960).

COURTS–
SEPARATE TRIALS OF ISSUES OF LIABILITY AND DAMAGES

O'Donnel v. Watson Bros. Transportation Company, 183 F. Supp. 577 (N.D., 1960)

Rule 21 of the Civil Rules of the Northern District of Illinois, promulgated pursuant to Rule 42 (b) of the Federal Rules of Civil Procedure provides, in substance, that in personal injury and other civil litigation a separate trial may be had upon the issue of liability and, in the event liability is sustained, the court may recess for pre-trial or settlement conference or proceed with trial on any and all the remaining issues before the court, before the same jury or before another jury, as conditions may require. In the instant case (a personal injury action arising out of an automobile collision), the jurors returned a verdict in favor of the plaintiff on the trial of issue of liability. The case thereupon was recessed for further settlement negotiations in chambers, whereupon the settlement offer of the defendant was increased but plaintiff's counsel requested that the trial on damages be continued pending consideration of the defendant's offer and for possible further negotiations. Defendant's counsel moved for leave to petition for the appointment of an impartial medical expert. The court concluded that in the instant case the practical necessities of dispensing justice required that the jury which determined the liability be discharged by agreement of the parties and that the issue as to damages be continued for trial before another jury to be impanelled in the event no settlement was effected.

DAMAGES–
TAXES, PERSONAL EXPENSES DEDUCTED FROM AWARD

Meehan v. Central Railroad Company of New Jersey, 181 F. Supp. 594, (S.D. N.Y., 1960)

In an action under the New Jersey wrongful death statutes and for conscious pain and suffering of decedent prior to his death the jury awarded to the plaintiff the sum of $315,000 on the cause of action for wrongful death and $10,000 on the cause of action for conscious pain and suffering and, to the latter item, $1,000 as punative damages was added. In an exhaustive opinion Judge Richard H. Levet of the United States District Court for the Southern District of New York allowed the award for conscious pain and suffering but reduced the jury verdict on the wrongful death claim from $315,000 to $235,000 applying the principles set forth in *O'Connor v. United States,* 269 F. 2d 578 (2 Cir. 1959), discussed in 27 Insurance Counsel Journal 6 (January, 1960). In assessing damages only the take-home pay of the decedent after income tax deductions was considered and the amount was further reduced by the decedent's personal expenses as well as a fair allocation of the usual family expenses for decedent's living. A discount rate of 3% was applied to find the present value of the prospective pecuniary loss arising out of the wrongful death. The court added to the award an allowance for income tax payable on the interest on the award over a period of 33 years. Compare, *McWeeney v. New York, N.H. & H.R.R. Co.,* 282 F. 2d 34 (2 Cir., 1960).

EVIDENCE–
THE ULTIMATE DEMONSTRATIVE EVIDENCE

Hall v. American Brewing Company, Civil District Court, Parrish of Orleans, New Orleans, Louisiana, No. 343-629 (November, 1960)

Plaintiff sued for damages as a result of allegedly incurring hemorrhoids following a chronic condition of nausea caused by the the discovery of worms in a purchased food product. On cross-examination of the plaintiff, counsel for the defendant-insurer exhibited a collection of worms to the witnesses then proceeded to eat a number of them, whereupon the plaintiff fled the courtroom. The jury, apparently impressed somewhat differently, found for the defendant after eight minutes of deliberation. (Contributed by A. R. Christovich, Jr., New Orleans, Louisiana, State Editor for Louisiana).

EVIDENCE–
TRAFFIC OFFENDER'S GUILTY PLEA IS ADMISSABLE IN NEGLIGENCE SUIT

Ando v. Woodberry, 203 N.Y.S. 2d 74, 8 N. Y. 2d 165 (1960)

In an action by a motorcycle policeman for injuries sustained in a collision between

the motorcycle and an automobile owned and operated by the defendants, the plaintiff attempted to prove the driver-defendant's plea of guilt in a traffic court proceeding arising from the same accident on the theory that such plea constituted an admission. The trial court excluded the proffered evidence. The Court of Appeals of New York in passing upon what it felt to be a question of first impression in that state held that such defendant's prior plea of guilty to a traffic offense should have been received as evidence of his asserted carelessness. The rationale of the court's decision was that only two possible grounds of exclusion suggest themselves; the first, that such testimony is hearsay and; the second, that its introduction violates public policy. Since the prior plea of guilt represents an admission it is not violative of the hearsay rule. Similarly, the court found no violation of public policy. Judge Van Voorhis dissented.

EXCESS LIABILITY– DUTY TO NEGOTIATE AND SETTLE

Chancey v. Amsterdam Casualty Company, 336 S.W. 2d 763 (Tex., 1960)

The insured sued his liability insurer to recover the amount of a judgment returned against the insured in excess of policy limits. From a judgment for the insurer the insured appealed contending that the lower court erred in sustaining an exception to insured's petition which alleged the failure of the insurer to "negotiate" for a settlement of the case and the refusal of the lower court to submit issues based on that allegation. The insured contended that inasmuch as the policy gives insurer the right to "investigate, negotiate and settle" any claim arising under the policy, this right is equally accompanied by the duty to negotiate as well as to settle. The Court of Civil Appeals of Texas affirmed the action of the lower court in holding for the insurer saying:

> "***No case had been cited, and we have found none which makes such a distinction. The ultimate responsibility of the insurer to the insured is to exercise such care and diligence which an ordinary, prudent person would exercise in the management of his own business. We cannot agree with appellant's contentions that the duty to negotiate is separate and apart from the duty to settle. It is our view that the duty to settle implies the duty to negotiate. These two duties cannot be separated as far as the basic obligation to the insured is concerned.***."

The court also sustained an instruction which read in part:

> "***an insurer does not necessarily become liable merely because the decision to reject an offer of settlement proves to be wrong; in other words, the duty to exercise ordinary care leaves room for an error in judgment without liability necessarily resulting therefrom."

(Contributed by J. Kirby Smith, Dallas, Texas, State Editor for Texas)

EXCESS LIABILITY– GOOD FAITH RULE DISCUSSED

Davy v. Public National Insurance Company, 5 Cal. Rptr. 488 (1960)

The insured, owner of a fleet of taxicabs, was sued by a police officer for injuries received as a result of a collision with one of insured's cabs. The personal injury action could have been settled for $4,500 but this offer was rejected by the insurer. A judgment in the amount of $24,268 was returned against the insured. The insured then brought suit against the insurer for the excess and obtained judgment for such amount. In holding that there was sufficient evidence to support the finding of the jury that the insurer did not exercise good faith in refusing to accept the offer to settle the personal injury action, the California District Court of Appeal, Fourth District, set forth the following resume of the "good faith" test :

> "Applying the foregoing general rules to a situation such as that present in the case at bar, we conclude that an insurer acts in good faith in rejecting an offer of settlement after it has undertaken a reasonably diligent investigation to determine the facts of the case, is acting upon the opinion of a reasonably qualified legal advisor, and is of the honest belief that the risk of an adverse verdict is one

which it would assume if there were no limits to its policy, providing the insured is informed of the offer of settlement, furnished with the result of the investigation made, and advised of the opinion upon which the rejection is based***."

EXCESS LIABILITY— JUDGMENT CREDITOR CANNOT RECOVER AGAINST INSURER

Sturgis v. Canal Insurance Co. of Greenville, S.C., 122 So. 2d 313 (Fla., 1960)

In *Canal Insurance Co. of Greenville, S. C. v. Sturgis*, 114 So. 2d 469 (Fla., 1959), the District Court of Appeal, First District, held that the judgment creditor of an insured has no cause of action against the insurer to recover the balance due on an unsatisfied judgment in excess policy limits. This case is discussed in 27 Insurance Counsel Journal 353 (July, 1960). The question was certified to the Supreme Court of Florida, 115 So. 2d 774 (Fla., 1959) as follows:

"Where plaintiff in an automobile accident suit has recovered a judgment in excess of the policy limits of the defendant's insurance policy, and where said policy contains the following provision:

'any person or organization, or the legal representative thereof who has secured such judgment or written agreement shall thereafter be entitled to recover under this policy to the extent of the insurance afforded by this policy.'

And where plaintiff has received payment of said policy limits but holds an unsatisfied judgment as to the excess, may the plaintiff maintain a suit directly against the insurer for recovery of the judgment beyond the limits of the policy, based upon the alleged negligence or bad faith of the insurer in the conduct or handling of said suit?"

In affirming the action of the District Court of Appeal the Supreme Court of Florida held:

"From our examination of the authorities cited in the briefs of counsel and from our independent research we have reached the conclusion that the District Court was correct in its decision that a judgment creditor may not maintain a suit directly against the insurer for recovery of the judgment in excess of the insurance policy limits under the circumstances of this case and the language of the insurance policy issued by the respondent."

FEDERAL COURTS— ALLEGATION AS TO JURISDICTIONAL AMOUNT BINDING ON PLAINTIFF

Facella v. Home Fire and Marine Insurance Co. of Cal., 184 F. Supp. 838 (D.C. N.J., 1960)

Homeowner-insureds brought suit against insurance company for loss by fire of home and furnishings alleging that the amount in controversy was $12,000. The insurance company removed to federal court whereupon the insureds moved to remand alleging by affidavit that the amount in controversy actually was below the necessary $10,000 jurisdictional sum. The United States District Court held that the insureds were bound by the allegations of their complaint, the statements therein as to jurisdictional amount being presumptively correct and the situation in fact at the time of the removal governing. Their subsequent affidavit could not alter this. Compare *Leehans v. American Employers Insurance Company*, 273 F. 2d 72 (5 Cir., 1959), discussed in 27 Insurance Counsel Journal 353 (July, 1960). (Contributed by J. Kirby Smith, Dallas, Texas, State Editor for Texas)

FEDERAL TORT CLAIMS ACT— GOVERNMENT HELD LIABLE FOR NEGLIGENCE IN MAKING FHA APPRAISAL

United States v. Neustadt, 281 F. 2d 596 (4 Cir., 1960)

Purchasers of a dwelling brought suit against the United States under the Federal Tort Claims Act to recover damages occasioned by the negligence of an agent of the FHA in making an appraisal of the property. The purchasers were aware of the fact that the property was inspected by a FHA appraiser and the contract of sale was executed conditioned upon the purchasers obtaining a loan secured by a FHA mortgage. Pursuant to agreement the sellers furnished the purchasers a written statement of the appraised value as so determined. It later

developed that there were defects in the dwelling necessitating the expenditure of several thousand dollars which defects should have been taken into consideration in the FHA appraisal. The government did not deny that the appraisal was faulty nor that the purchasers were injured thereby but defended on the ground that plaintiffs' claim arose out of misrepresentation which is excluded from coverage of the Act. The Court of Appeals for the Fourth Circuit, in affirming a verdict of $8,000 in favor of the plaintiff, held that the Federal Tort Claims Act was applicable reasoning that the instant case did not fall within the exclusion of the Act pertaining to misrepresentation but, rather, was a failure of the United States properly to perform a specific duty which it owed to the plaintiff, namely, to produce a non-negligent appraisal.

INTERSPOUSAL IMMUNITY PREVENTS SUIT BY WIFE AGAINST HUSBAND'S PARTNERSHIP

Eule v. Eule Motor Sales, 162 A. 2d 601 (N. J., 1960)

Plaintiff sustained personal injuries when a motor vehicle operated by her husband and owned by Eule Motor Sales, a partnership, collided with another automobile. Plaintiff's husband was a general partner in Eule Motor Sales. Plaintiff brought suit against Eule Motor Sales as well as the operator of the other vehicle and the lower court sustained the motion for summary judgment filed by the partnership. The lower court's ruling was based both on non-agency as well as interspousal immunty. On appeal the plaintiff contended that she should be allowed to maintain an action against the partnership notwithstanding the fact that her husband was a member thereof and, further, it was urged that interspousal immunity should be abolished in all tort actions. The Superior Court of New Jersey, Appellate Division, affirmed the action of the lower court refusing to distinguish the partnership entity from the individual members thereof. The court held that for purposes of conforming with the public policy implicit in New Jersey law her husband must be regarded as a litigant and a real party in interest and, consequently, the plaintiff's action falls within the interdiction of the statute whch prohibits interspousal suits in tort actions.

LIABILITY–
CHURCH LIABLE FOR INJURY TO BINGO PLAYER

Blankenship v. Alter, 167 N.E. 2d 922 (Ohio, 1960)

A participant at a bingo game operated by a church on church premises sustained personal injuries when a chair supplied by the church collapsed. The plaintiff paid an admission charge to engage in the game of bingo and the game was open to the public and operated by the church for money raising purposes. The plaintiff was not a member of the church and came there solely for the purpose of playing bingo. The participant sued the trustee of the church to recover damages for such injuries. The Supreme Court of Ohio held that the action could be maintained, the church having conducted the bingo game for substantial profit and thereby having removed itself from the protection it might have claimed as a religious and charitable institution.

LIABILITY –
DELIVERY OF DEER TO ZOO HELD TO BE A GOVERNMENTAL FUNCTION

Smith v. City of Birmingham, 121 So. 2d 867 (Ala., 1960)

Plaintiff sued the City of Birmingham alleging that she was injured when attacked by a wild deer which had escaped while being transported by city employees to a public park, the deer having been the property of a private organization which operated under a contract with the city in maintaining a zoo in such park. The plaintiff alleged that the deer escaped through the negligence of the city's employees. The Supreme Court of Alabama affirmed the judgment of the lower court in sustaining a demurrer to the complaint, holding that the alleged negligent acts of the city's employees were committed in the performance of their duties in the operation and maintenance of a city owned recreational park which function was public and governmental and, therefore, the city was not liable for any injuries caused by the wrongful or negligent performance of such function. That the animals were owned by a private organization which was permitted to maintain a zoo in the park on a contract with the city did not change the nature of the duties performed by the city's employees.

LIABILITY—
DOCTRINE OF EXCLUSIVE CONTROL NOT APPLICABLE TO FIREWORKS DISPLAY

Haddon v. Lotito, 161 A. 2d 160 (Pa., 1960)

The plaintiffs were injured while attending and witnessing a public fireworks display at a public picnic park on July 4, 1956. They brought suit against the producer of the exhibition which resulted in the entry of compulsory non-suit at trial. The Supreme Court of Pennsylvania affirmed the lower court action, declining to treat a fireworks display as an ultra-hazardous activity and refusing to apply the theories of absolute liability or exclusive control so as to impose liability on the defendant. Further, the court concluded that there was no evidence sufficient to sustain the finding of any negligence on the part of the defendant. Justices Musmanno and Bok dissented.

LIABILITY—
FOUR YEAR OLD PLAINTIFF RECOVERS FOR INJURIES INFLICTED BY SIX YEAR OLD DEFENDANT

Baldinger v. Banks, 201 N.Y.S. 2d 629 (1960)

The plaintiff, a four year old girl, walked from her nearby home to a lawn area where several young boys, including the defendant, age six, were playing tag. The infant defendant pushed the plaintiff hard enough to cause her to fall to the ground resulting in a fracture of her elbow. The trial proceeded and was concluded on the basis of an alleged assault and battery. The New York Supreme Court held that the defendant's intent to inflict upon the plaintiff an offensive bodily contact, known to him to be offensive, was established by the fair weight of the evidence. The push was the proximate cause of the plaintiff's fall and the resulting injuries for which the defendant is liable although the proof fails to show an intent on his part to inflict bodily harm or that the fall and the resulting injuries were or should have been foreseen. The court felt that the proof indicated that the defendant, despite his tender years, had the capacity of mind to know and did, in fact, know that his act was offensive and that it was so intended.

LIABILITY—
UNEMANCIPATED INFANT MAY MAINTAIN TORT ACTION AGAINST ESTATE OF DECEASED PARENT

Brennecke v. Kilpatrick, 336 S.W. 2d 68 (Mo., 1960)

A minor, by her father as next friend, brought a personal injury action against the estate of the minor's mother for injuries sustained in an automobile accident, the mother having been driving the automobile and having been killed instantly. The trial court sustained the defendant's motion to dismiss on the ground that an unemancipated minor child could not recover against its parent where the accident is based on negligence. After having reviewed the authorities, the Supreme Court of Missouri held that the suit could be maintained and that public policy does not prohibit such a suit inasmuch as the doctrine of intrafamily immunity expires upon the death of the person protected and does not extend to such decedent's estate. Death terminates the family relationship and there is no longer in existence any relationship in reasonable contemplation of the doctrine and rationale of the rule of parental immunity.

LIABILITY—
UNEMANCIPATED INFANT MAY NOT MAINTAIN COURT ACTION AGAINST PARENT

Schwenkhoff v. Farmers Mutual Automobile Ins. Co., 104 N.W. 2d 154 (Wis., 1960)

The Supreme Court of Wisconsin once again has reaffirmed its adherance to the basic rule that an unemancipated minor cannot maintain an action in tort against his parent for personal injuries sustained in an automobile accident due to the negligence of the parent. The instant case had been before the court previously in *Schwenkhoff v. Farmers Mutual Automobile Ins. Co.,* 93 N.W. 2d 867 (1959). The court observed that the Wisconsin Legislature consistently has failed to enact a bill designed to change this basic rule. The court further noted that the new allegations contained in the amended complaint, raising constitutional questions merely presented to the court issues considered in its previous decision.

**LIFE INSURANCE—
BENEFICIARY'S VOLUNTARY MANSLAUGHTER PLEA DOES NOT BAR ACTION UNDER POLICY**

Davis v. Aetna Life Insurance Company, 279 F. 2d 304 (9 Cir., 1960)

Aetna issued two policies on the life of Sylvia S. Davis, both policies naming her husband, Willie A. Davis, as primary beneficiary. In one of the policies she designated her parents as secondary beneficiaries and in the second her estate was so designated. On November 23, 1956, Willie Davis killed Sylvia and thereafter he pleaded guilty to a charge of voluntary manslaughter and was duly sentenced to confinement. Aetna filed this interpleader action, paying the proceeds of the two policies into the registry of the court. In his answer Willie Davis alleged that the death of his wife was accidental and did not constitute manslaughter and that he was entitled to the proceeds of the policy. A California statute provides that no person convicted of the murder or voluntary manslaughter of a decedent shall be entitled to any portion of the estate. The lower court entered summary judgment denying Davis' claim and upon appeal, the United States Court of Appeals for the Ninth Circuit reversed and remanded the cause holding that the appellant's conviction in a criminal case is admissable in a civil case, not as a judgment establishing the fact, but as an admission against interest. A plea of guilty in a criminal case may be explained in subsequent civil action. The appellant should have been allowed the opportunity of presenting such evidence as he may have in support of his contention that the killing of his wife was accidental. Circuit Judge Pope dissented.

**LIFE INSURANCE—
CHANGE OF BENEFICIARY NOT EFFECTED BY MERE INTENTION**

Jaudon v. Prudential Insurance Company of America, 279 F. 2d 730 (6 Cir., 1960)

Insurer brought interpleader action against insured's widow, who was named beneficiary of a group life policy, and a sister of the insured, who claimed to have been designated as beneficiary. The subject policy provided that the beneficiary might be changed by written notice through the employer to the insurer, which change would take effect when due acknowledgment thereof was furnished the insured. The policy provisions were not complied with. The sister, however, claims that she verbally was designated beneficiary and thereby substituted for the widow by reason of the following facts: On Friday, December 13, 1957, the insured went to the office of his employer and he stated that he wanted to change the beneficiary in his policy from his wife to his sister not indicating which of two sisters was intended. However, the insured never had a chance to fill out the proper form inasmuch as he met his death on the following Sunday as the result of an invited affray. The court held that under Tennessee law a mere unexecuted intention on the part of the insured to change his beneficiary is not enough. There must be substantial compliance with the provisions of the policy for the change of beneficiary to be effected. Assuming that the insured had intended to designate this particular sister as beneficiary, nevertheless, he did nothing definite to effectuate this intention.

**LIMITATION OF ACTIONS—
INSURER NOT ESTOPPED FROM DENYING LIABILITY AFTER EXPIRATION OF STATUTE OF LIMITATIONS**

Carver v. Liberty Mutual Insurance Company, 277 F. 2d 105 (5 Cir., 1960)

Plaintiff was injured in an accident which occurred when the automobile in which she was a passenger was hit by a truck driven by an ice cream vendor, the truck bearing a sign advertising Melba Ice Cream. In the mistaken belief that the ice cream vendor was an employee or agent of the Melba Ice Cream Company, plaintiff sued Melba's insurer under the Louisiana Direct Action Statute and did not join the ice cream vendor as a co-defendant. Melba was a stranger to the accident and the vendor in no sense was its agent or employee. Plaintiff made no demand on Melba or its insurer until the complaint was served on the insurer, whereupon the insurer obtained a 60 day extension for pleading in order to investigate the accident. The extension was granted and on March 30, 1959, the insurer filed a motion for summary judgment, this motion having been filed one day after the expiration of the one year prescriptive period provided for tort actions in Louisiana.

The plaintiff contended that the insurer was estopped to deny that the ice cream vendor was the employee or agent of the insured Melba for the reason that the insurer had waited until after the prescriptive period had run before filing its motion. The Court of Appeals for the Fifth Circuit, affirming the action of the lower court which sustained the motion for summary judgment, held that the insurer was not so estopped, observing:

> "***if a plaintiff has sued the wrong defendant, it is the plaintiff who has made the mistake. It is not up to the defendant to help the plaintiff correct the mistake, regardless of the effect of defendant's silence on the application of the law of liberative prescription."

PRODUCTS LIABILITY–
LIABILITY INSURER HAS CAUSE OF ACTION FOR INDEMNITY AGAINST MANUFACTURER

Allied Mutual Casualty Corp. v. General Motors Corp., 279 F. 2d 455 (10 Cir., 1960)

The insured of Allied Mutual, while driving a new Buick on a downhill grade, applied her brakes but they failed and the car then ran down the hill killing one pedestrian, injuring another and causing extensive property damage. As a consequence, several suits were filed against the insured which Allied Mutual settled. Allied Mutual then brought this action against Parker Buick Company and General Motors Corporation for indemnity in the amount of the settlement sum on the ground that the negligence of its insured, if any, was only secondary and that the defendants' negligence was primary and the proximate cause of said accident and damages. The lower court rendered summary judgment for the defendant and on appeal the United States Court of Appeals for the Tenth Circuit reversed and remanded. The court held that Allied Mutual unquestionably was subrogated to any and all rights of the insured and that the insured's rights to indemnity are determined from Missouri law. "Indemnity" is a right which inures to a person who has discharged a duty which is owed by him but as between himself and another should have been discharged by the other. It implies a primary liability in one person, although a second person is also liable to a third party. It rests upon the difference between the primary and the secondary liability of two persons, each of whom is made responsible by law to an injured party. The court believed that a factual situation was presented as to the nature of the insured's liability with respect to the claims which were settled. Allied Mutual was not a volunteer since its insured could have been adjudged liable to each claimant for driving a car having defective brakes and these payments were made as a result of settlement negotiated in good faith after defendants were given notice of the claims.

PRODUCTS LIABILITY–
SALK VACCINE MANUFACTURER HELD LIABLE FOR BREACH OF IMPLIED WARRANTY OF MERCHANTABILITY

Gottsdanker v. Cutter Laboratories, 6 Cal. Rptr. 320 (1960)

Suits were brought against the manufacturer of salk vaccine for damages sustained by minors when the allegedly contracted poliomyelitis as a result of inoculation of the vaccine. The jury determined that the manufacturer was not guilty of negligence but brought in a verdict for the plaintiffs on the theory of a breach of implied warranty of merchantability. On appeal the California District Court of Appeal held that a manufacturer of vaccine intended for introduction into the body of a human being is liable to the person into whose body it is introduced for a breach of implied warranty of fitness for the purpose for which it is sold although there is no privity of contract between manufacturer and such person. The court equated the vaccine to food, treating both as being intended for human consumption, and then followed the established California rule that the consumer of a food product may recover from the manufacturer upon implied warranty of fitness.

RELEASE–
CONTRIBUTION NOT BARRED BY EXECUTION OF RELEASE

Buckley v. Basford, 184 F. Supp. 870 (N.D. Me., 1960)

Driver-owner of automobile and other occupants thereof brought suit for personal injuries and property damages arising out of

collision with defendant's truck. Defendant filed a counterclaim against plaintiff-driver seeking contribution from her for one-half of the amount of any damages for which he may be found liable to the other plaintiffs. The plaintiff-driver answered the counterclaim and affirmatively sought dismissal of the counterclaim on the ground that the defendant's claim for contribution was barred by a release executed by the defendant and his wife and previously given to the plaintiff-driver. It appeared from the stipulation of facts that no pressure was exerted on the defendant or his wife to obtain the release but that the sum paid for the release was exactly the amount of the actual out-of-pocket expenses incurred by the defendant and his wife, $123.27. The United States District Court concluded that despite the general language of the release, it did not clearly embrace anything other than such out-of-pocket expenses and, applying the fundamental principle that a written instrument must be construed most strictly against the party who prepared it (in this case, being the plaintiff's representative) the release would not bar contribution. The affirmative defense of the counterclaim, therefore, was dismissed. (Contributed by A. C. Epps, Richmond, Virginia)

TRIAL TACTICS— CONDUCT OF COUNSEL FOR PLAINTIFF AND DEFENDANT CRITICIZED

Rubinstein v. Pennsylvania Railroad Company, 201 N.Y.S. 2d 279 (1960)

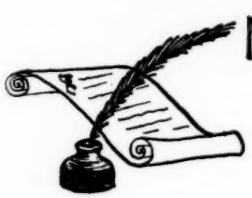
In another of a growing number of cases wherein the courts have felt constrained to criticize the conduct of counsel in the trial of personal injury actions, the New York Supreme Court, Appellate Division, reversed a lower court's judgment for automobile passengers against the railroad and ordered a new trial. The court stated:

> "***Conduct of counsel during the trial added to the confused atmosphere and precluded a trial fair to either plaintiffs or defendants. While the criticism in the main is directed to the plaintiffs' counsel, defendants' counsel cannot escape entirely this criticism. Trial tactics which appear calculated to influence the jury by considerations which are not legitimately before them, side remarks to the jury on the conduct of opposing counsel, the witnesses, or improper comments on and unfair characterization of the testimony as it is given will not be condoned. It is unfortunate that this conduct requires a new trial in the interest of justice."

WORKMEN'S COMPENSATION— INDUSTRIAL BOARD HAS BURDEN OF PROOF TO ESTABLISH THAT NO BENEFICIARIES EXIST

Industrial Accident Bd. v. Texas Employer's Ins. Ass'n, 336 S.W. 2d 216 (Tex., 1960)

An employee was killed in a butane gas explosion. The deceased employee was known to his employer as Pedro Robles and he had presented a Social Security card No. 459-52-1954 issued in that name. However, one Pedro Robles with the same Social Security number is admittedly alive today. The deceased's body was badly burned in the explosion and fire and all efforts to determine his true identity proved futile. Under these circumstances the Industrial Accident Board of Texas contended that the insurer was liable to pay the statutory sum of $1,500 into the Second Injury Fund pursuant to Texas statute which provided that such sum be paid where there is no beneficiary surviving the deceased employee. The Texas Court of Civil Appeals found for the insurer, holding that since there was no direct evidence available as to whether the deceased was or was not survived by any statutory beneficiary entitled to compensation, the burden of proof had not been carried by the board. The court observed that under the Workmen's Compensation Act the burden of proof is placed on all claimants and that, therefore, the board, being a claimant, must bear such burden.



Reviewing the LAW REVIEWS

ROBERT J. NORDSTROM*
Columbus, Ohio

THE RIGHT OF PRIVACY

Judge Biggs (in *Ettore v. Philco Television Broadcasting Co.*, 229 F. 2d 481 (3d Cir. 1956)) described the law of privacy as "still that of a haystack in a hurricane". Dean William L. Prosser cites this colorful description in his article but suggests a way to still the hurricane and to reassemble the haystack. He does this by suggesting that the law of privacy involves not one tort but four distinct types of invasions of four different interests of the plaintiff. These are listed by Dean Prosser as:

1. Intrusion upon the plaintiff's seclusion or solitude, or into his private affairs.
2. Public disclosure of embarrassing private facts about the plaintiff.
3. Publicity which places plaintiff in a false light in the public eye.
4. Appropriation, for the defendant's advantage, of the plaintiff's name or likeness.

He then proceeds to a discussion of at least two hundred cases falling within these four categories. A separate section deals with problems involving public figures and public interest. Seven pages are devoted to a discussion of limitations on the right of privacy and defenses to claims of invasion of this right.

This is a valuable article for lawyers dealing with legal problems centering on the right "to be let alone". It is written in Dean Prosser's usual clear style and contains 311 footnotes. This collection of cases, alone, is well worth the attention of the practicing bar. Prosser, Privacy, 48 California Law Review 383-423.

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AUTOMOBILE LIABILITY INSURANCE

Suppose A permits another person to use or operate his automobile, which is covered by a liability insurance policy. Due to his negligence, the permittee becomes involved in an accident resulting in personal injuries or property damage to a third person and a judgment against himself. Is the permittee's liability to the injured party covered by A's insurance?

The author begins his article in the Iowa Law Review with this paragraph and question. He indicates that the answer turns on the existence and interpretation of the omnibus clause in the insured's policy. These clauses typically expand the word "insured" to cover also any person using the automobile and "legally responsible" for its use, provided the use is with the "permission" of the named insured. The article deals primarily with the meaning of those two phrases: *permission* and *legally responsible.*

Under "permission", the author discusses the meaning of permission; who can give permission—especially when the named insured is a corporation; how permission may be given—herein a treatment of implied consent; and scope of the permission. This last section points up the three views taken on scope: (1) permission to use the vehicle, (2) permission to the particular use of the vehicle, and (3) permission to minor deviations from the initial use. This requires a closer look at uses for the benefit of the bailor, the bailee, and for their mutual benefit.

The "legally responsible" portion of the article covers only two pages and concludes that this phrase refers "to the relationship between one who comes within that description and the injured party, and not to the relationship between the operator and the named insured. . . ."

The article is well documented by refer-

ence to at least 300 cases. Ashlock, Automobile Liability Insurance: The Omnibus Clause, 46 Iowa Law Review 84-126.

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TORTS BETWEEN PARENT AND CHILD

Automobile accidents, most often with liability insurance, have caused an increased interest in the possibility of personal injury actions between a parent and child. This article by Professor McCurdy (Harvard University) examines cases dealing with this subject. It begins with the general common law review of no liability, compares the legal problems to those of suits between spouses, and then concentrates on cases since 1930.

Among the questions answered by this article are these:

1. May a child sue an employer of a parent negligently injuring the child?
2. What effect is given to the fact that the tort arose in the course of the parent's business?
3. What effect should be given to the existence of liability insurance?
4. Should a distinction be made between different kinds of torts?
5. Does emancipation of the child (or the fact that the child is an adult) remove the reason for no liability?

The author's conclusion is that it is still "the general view" that personal injury torts between parent and child cannot be maintained. Some exceptions have been made in matters of wilful injury, liability of the parents' employer, insurance against business risk, and vocational or business nonparental capacity. The article is worthy of careful reading. McCurdy, Torts Between Parent and Child, 5 Villanova Law Review 521-560.

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REMEDIES FOR THE UNUSUAL SITUATION

The Spring, 1960, issue of the Illinois Law Forum is devoted to a consideration of remedies for the unusual situation. It is aimed primarily at the law of Illinois but the ideas expressed are not confined to any one jurisdiction. Its titles indicate the breadth of the symposium:

1. Remedies and Rescission (Author: Milton M. Hermann).
2. Interpleader, Declaratory Judgments and Bills Quia Timet (Author: George B. Fraser).
3. Specific Performance (Author: Ivan A. Elliott, Jr.).
4. Mandamus, Prohibition, Quo Warranto, and Ne Exeat (Author: Richard B. Allen).
5. Ejectment, Forcible Entry and Detainer, and Distress or Distraint (Author: Kenneth J. Schuessler).

Because of the divergence of the subjects covered, no attempt is made here to summarize them. The issue is, however, worth having in the library as a beginning point for research into that "unusual situation" that has a way of becoming usual in most lawyers' offices. Remedies for the Unusual Situation, 1960 Univ. of Ill. Law Forum 1-138.

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FEDERAL COURTS AND TRIAL BY JURY

Twenty-three years of the Federal Rules of Civil Procedures have proved that simplified procedure can remove many of the difficulties inherent in seeking to reach a just result in any law suit. This article indicates that these rules have, however, produced at least "one notable headache". This centers in the right to a jury trial on disputed issues of fact. The author states that three tests have been suggested by the cases and by law reviews: (1) a determination of whether the case is "basically legal" or "basically equitable", (2) a classification of each issue as legal or equitable, and (3) a classification depending on desirability of jury trial. He finds all three to be unsatisfactory and proposes a fourth test which ties the relief sought and the position of the parties on the question of a jury trial to the pre-rule practice.

The main portion of the article centers on how the proposed solution would work

when the plaintiff is seeking both legal and equitable relief, when the plaintiff is ask- for either legal or equitable relief, when the case involves an equitable claim and a legal counterclaim, when the case involves a legal claim and an equitable counterclaim, and when a declaratory judgment is sought. In each instance the proposed post-rule result is made similar to what the pre-rule result would have been. This, the author believes, is necessary because of Rule 38 (a) which declares that the right to a jury trial as declared by the Seventh Amendment or by a statute of the United States "shall be preserved to the parties inviolate". Undoubtedly some lawyers will take issue with an approach which connects present rights so closely with past practice, but the article is worthy of a close reading by the trial lawyer. McCoid, Right to a Jury Trial in the Federal Courts, 45 Iowa Law Review 726-742.

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NONDIVERSITY CASES AND APPLICABLE LAW

In one of the well written comments in the area of procedure the Yale Law Journal has presented an excellent discussion of the rule of decision to be applied in nondiversity cases. Much has been written on the effect *Erie R. R. v. Tompkins* (304 U. S. 64 (1938)) has had on diversity cases; less critical analysis has been centered on the nondiversity case—although recent attention has increased notably.

Both problems begin with a consideration of the Rules of Decision Act which provides:

> ". . . . the laws of the several states, except where the constitution, treaties, or statutes shall otherwise require or provide, shall be regarded as rules of decision in trials at common law in the courts of the United States in cases where they apply."

Erie R. R.—a diversity case—held that "laws of the several states" included case law as well as statutes. No similar sweeping decision has applied to nondiversity problems. This comment analyzes the nondiversity cases in which the United States is a party and in which a federal statute is being interpreted. Both situations are carefully analyzed but no uniform rule is proposed. One of the major ideas running through both sections is that state law should be applied unless some reason for uniformity of result from state to state is involved. "Federal law does not replace state law simply because the United States is a litigant, or because a federal statute is somehow involved. State law must be found unsuitable for certain specific reasons." Even when some reason dictates rejection of state law, the federal law should be formulated by the court not to promote the interests of the federal government but "to discover the rule of state or federal common law which it would find preferable if the controversey involved two private parties".

This comment cannot be summarized into any two or three paragraphs. It should be read carefully by all lawyers who have cases in which the United States is a party or in which a statute of the United States is involved. Its 162 footnotes supplement its analysis. Rules of Decision in Nondiversity Suits, 69 Yale Law Journal 1428-1452.

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ARTICLES AND COMMENTS

The titles of additional law review writings are listed below for the lawyer who may have the specific problem in his office:

Damages

1. The Motion for New Trial Based on Inadequacy of Damages Awarded (Author: Donald R. Wilson), 39 Neb. L. Rev. 694-738 (Univ. of Nebraska College of Law, Lincoln, Neb.).
2. Calculating Damages for Pain and Suffering: The Mathematical Formula Device (Comment), 1960 Wash. Univ. L. Quarterly 302-311 (Washington Univ. School of Law, St. Louis, Mo.).

Evidence

3. Some Reflections on Dying Declarations (Author: Charles W. Quick), 6 How. L. Jour. 109-134 (Howard Univ. School of Law, Washington 1, D. C.).
4. Rules of Evidence in Disbarment, Habeas Corpus, and Grand Jury Pro-

ceedings (comment), 58 Mich. L. Rev. 1218-1232 (Univ. of Michigan Law Review, Hutchins Hall, Ann Arbor, Mich.).

5. Sound Recording Devices Used as Evidence (Author: Peter P. Roper), 9 Cleve-Mar. L. Rev. 523-534 (Clevelend-Marshall Law School, 1240 Ontario St., Cleveland 13, Ohio).
6. Objections to Former Testimony (Comment), 35 Ind. L. Jour. 454-462 (Indiana Univ. School of Law, Bloomington, Ind.).
7. Medical Treatises As Evidence—Helpful But Too Strictly Limited (Comment), 29 Cinn. L. Rev. 255-263 (University of Cincinnati Law Review, Cincinnati, Ohio).
8. Psychiatry in Civil and Criminal Trials (Author: John J. Broderick) 4 Notre Dame Lawyer 508-524 (Notre Dame Law School, Notre Dame, Ind.).
9. Psychiatric Opinion as to Credibility of Witnesses: A Suggested Approach (Author: Michael Juviler), 48 Cal. L. Rev. 648-683 (Univ. of California School of Law, Berkeley, Cal.).
10. Governmental Official's Absolute Privilege in Libel and Slander Suits (Comment), 55 Northwestern Univ. L. Rev. 228-238 (Northwestern University School of Law, Chicago 11, Ill.).

Insurance

11. Tax-Exempt Interest of Life Insurance Companies: A Study in "Discriminatory" Taxation, 70 Yale L. Jour. 15-44 (The Yale Law Journal, 401 A Yale Station, New Haven, Conn.). Note: This is an excellent article dealing with the 1959 amendments to §805 of I.R.C., 1954. All insurance tax counsel should read this article.

Procedure

12. Limitations upon State Use of Forum Non Conveniens in FELA Actions (Comment), 27 Univ. of Chicago L. Rev. 545-554 (Univ. of Chicago Law School, 5750 Ellis Avenue, Chicago 37, Ill.).
13. Stay of Federal Proceedings in Deference to Concurrently Pending State Court Suits (Comment), 60 Yale L. Jour. 684-710. (Columbia Univ. Law School, Kent Hall, New York 27, N. Y.).
14. Contractual Restrictions on the Forum (Author: G. Merle Bergman, 48 Cal. L. Rev. 438-447 (Univ. of California School of Law, Berkeley, Cal.).

Torts

15. The Manufacturer's Duty to Warn—A Higher Order of Enterprise Responsibility (Comment), 11 West. Res. L. Rev. 602-615 (Western Reserve Univ. School of Law, Cleveland 6, Ohio).
16. The Wife's Cause of Action for Loss of Consortium (Comment), 20 La. L. Rev. 731-738 (Louisiana State Univ. Law School, Baton Rouge 3, La.).
17. Trespass Quare Clausum Fregit—Strict Liability or Not (Author: Leigh M. Clark), 12 Ala. L. Rev. 301-311 (Univ. Alabama School of Law, University, Ala.).

WRITINGS OF LOCAL INTEREST

Alabama

Res Judicata and the Common Automobile Accident—Problem of Splitting the Cause of Action (Comment), 12 Ala. L. Rev. 364-378 (Univ. of Alabama School of Law, University, Ala.).

Proof of Foreign Law—Uniform Judicial Notice of Foreign Law Act (Comment), 12 Ala. L. Rev. 421-425 (Univ. of Alabama School of Law, University, Ala.).

California

Valuation Evidence in California Condemnation Cases (Comment), 12 Stan. L. Rev. 766-807 (Stanford Univ. Law Review, Stanford, Cal.).

Uninsured Motorist Insurance: California's Latest Answer to the Problem of the Financially Irresponsible Motorist (Comment), 48 Cal. L. Rev. 516-540 (Univ. of California School of Law, Berkeley, Cal.).

Florida

Fourth Survey of Florida Law—Part Two, 14 Univ. of Miami L. Rev. 501-707 (Univ. of Miami L. Rev., Coral Gables 46, Fla.).

—Insurance (Author: Herbert A. Kuvin), pages 584-601.

—Torts (Author: Sam Daniels), pages 602-633.

Illinois

Remedies for the Unusual Situation (This issue is discussed above), 1960, Univ. of Ill. Law Forum 1-138 (Univ. of Illinois College of Law, Urbana, Ill.).

Kansas

The Rear-End Collision Doctrine as a Theory of Negligence in Kansas (Author:

Russell D. Jacobson), 28 Univ. of Kan. City L. Rev. 41-72 (Univ. of Kansas City Law Review, Kansas City 10, Mo.). Note: The author has also collected a number of Missouri cases on this subject in this article.

Kentucky

Contribution and Indemnity among Joint Tortfeasors (Comment), 48 Ky. L. Jour. 550-562 (Univ. of Kentucky College of Law, Lexington, Ky.).

Nebraska

Waiver of Right to Appeal (Comment), 39 Neb. L. Rev. 739-756 (Univ. of Nebraska College of Law, Lincoln, Neb.).

Ohio

Joint Bank Accounts in Ohio (Author: Daniel B. Close), 11 West. Res. L. Rev. 511-537 (Western Reserve Univ. School of Law, Cleveland 6, Ohio).

Waiver of Ohio's Dead Man Statute (Comment), 11 West. Res. L. Rev. 630-648 (Western Reserve Univ. School of Law, Cleveland 6, Ohio).

Oklahoma

Denials in an Oklahoma Answer (Author: Dwight Morgan), 13 Okla. L. Rev. 288-304 (Univ. of Oklahoma College of Law, Norman, Okla.).

Tennessee

Wrongful Death Actions in Tennessee (Author: T. A. Smedley), 27 Tenn. L. Rev. 447-500 (Univ. of Tennessee College of Law, Knoxville, Tenn.).

Texas

Restrictions on Doctors' Testimony in Personal Injury Cases (Author: Roy R. Ray) 14 Southwestern L. Jour. 133-149 (Southern Methodist Univ. School of Law, Dallas 5, Tex.).

Texas Remittitur Practice (Author: Eugene L. Smith), 14 Southwestern L. Jour. 150-168 (Southern Methodist Univ. School of Law, Dallas 5, Tex.).

Virginia

Summary Judgment in Virginia (Author: Thomas D. Terry), 2 William and Mary L. Rev. 353-380 (William and Mary Law Review, Williamsburg, Va.). Note: this article compares Virginia's Summary Judgment Rule with Rule 56 of the Federal Rules of Civil Procedure.

The Defendant is Insured (Comment), 2 William and Mary L. Rev. 475-484 (William and Mary Law Review, Williamsburg, Va.).

Wisconsin

Distinction between Assumption of Risk and Contributory Negligence in Wisconsin (Comment), 1960 Wis. L. Rev. 460-477 (Univ. of Wisconsin Law Review, Madison, Wis.).

Contribution Among Joint Tortfeasors (Comment), 1960 Wis. L. Rev. 478-494 (Univ. of Wisconsin Law Review, Madison, Wis.).

OUR READERS SPEAK

Readers of the Journal are invited to use this department as a place to express their thoughts on subjects of insurance law, trial practice, and the like. The opinions expressed are, of course, those of the writers and are not necessarily the views of the Journal or the Association.

Editor of the Journal
Dear Sir:

Recent issues of Insurance Counsel Journal presented thoughtful articles well prepared on the subject of damages dealing principally with personal injury cases related to insurance company losses, notably articles by Mr. Harry J. LaBrum of the Philadelphia bar, Mr. G. I. Whitehead, Jr., Vice-President of the United States Aviation Underwriters, Inc., Mr. Edward W. Schroeder, Vice-President of All-State Insurance Company. Indeed the solvency of liability underwriters is of genuine concern to those representing the interests of the injured person whose injury was caused by the negligence of another.

It may be said that the basic interest of a plaintiff's lawyer is to get as much as he can for his injured client, as it may be said that basically the interest of the adjuster and the insurance company's counsel is to keep the settlement at the lowest possible figure. Because a segment of the plaintiff's trial bar have spent many hard working hours, nights and weekends learning to improve their skill and the presentation of a case, be it for settlement or for trial, and have overcome the lead long held by the highly efficient defense counsel, they have been abused, ridiculed, their integrity questioned, as well as their morals, and ethical concepts. Usually these things aren't resorted to by anyone who has a sound argument in logic supported by reasons. It is a last act of desperation.

Assuredly there are many defense lawyers who must believe in their hearts that their brethren on the other side of the table are not bereft of morals, ethics or integrity, so I believe that a solution to a problem that is not only the insurance company's problem but the plaintiff's problem should be sought in areas other than abuse of individuals, and there are a few unconscionable ones on both sides. The problem is here explored from a standpoint that has rarely made print.

The author, reviewing the last twenty cases disposed of by him finds that none could be settled before suit. Nine were settled after suit. Eleven were tried, and eight were won and three lost. In the trial of a rear end collision case that occurred at a traffic light, the plaintiff unquestionably received a painful whiplash injury from which he suffered many months. Unfortunately at the time of the injury he was on his way to the hospital to take therapy treatments for a neck injury received two weeks previously when he backed into an airplane wing at work. One can readily see the difficulty of assessing the damages due to that amount of injury received in the collision from the amount of injury received two weeks earlier. I received an offer of $5,000.00 to settle this in an adjoining rural community, and turned it down only because of the experience where cases were won of getting verdicts larger than the offers. In that case, the defense counsel had that case correctly evaluated. The verdict was $5,000.00.

In another case of head injury, we turned down an offer of $3,000.00 and the verdict was $3,000.00.

In a case in which a man received a fractured patella, we refused an offer of $1,500.-00. The verdict was $7,000.00.

In a case where another man's car was struck in the rear end by a heavy truck, he received genuine and long lasting painful neck injury. His loss of earnings and medical expense alone amounted to $5,000.00. This case went to trial about three years after the injury. On the day of trial, defense counsel offered $6,000.00. The morning of trial, plaintiff's previous demand of $35,000.00 was reduced with great reluctance to $30,000.00. The verdict was $42,-500.00.

In another case, the defendant's employee and agent actuated a dangerous piece of equipment without first seeing if it was safe to do so and admittedly from the witness stand, without looking first to see if anyone was near the device that was set in motion and without calling a warning of his intention to acuate it, when he knew there were many other workmen about and in that immediate vicinity. Defense counsel in this case is a fine and honorable lawyer and an able one of comprehensive experience in the author's community, but said he failed to see any liability, so we were offered nothing to settle this case. Plaintiff sustained severe disabling permanent injury to his right hand, preventing the use of tools in his right hand or even being able to pick up a wire with his right hand. He was a right-handed electrician. We offered to settle this case for $36,000.00, finally willing to take even a bit less. The verdict was $40,000.00.

In another case of a mismatched blood transfusion that resulted in the death of plaintiff's wife, an offer of $4,000.00 was made, which we refused. We offered to settle for $20,000.00. The jury returned a verdict of $25,000.00.

The author, being a trial lawyer of only ordinary skill possessed by most trial lawyers, has reason to believe that these observations are not peculiar to his own practice, but have been the experience of most plaintiff's lawyers. Our side of the trial table often wonders what sort of recommendations to the insurance company by its counsel must accompany reports they make of our interest and our efforts to settle a case. Certainly it is recognized that a few lawyers will file any kind of a case in the hope of getting settlements, but the purpose of this article is not to deal in the realm of legalized blackmail, but speaks only of meritorious cases where there is apparent liability. Certainly men who handle many claims of many kinds can readily distinguish the real non-liability cases from the very real liability cases. Why then are so many liability cases tried? One cannot believe that the offers made to settle cases by the plaintiff are handled by stupid or incompetent people. What then is the answer? Is it avarice of defense counsel to make a fee? Is it parsimony at the home office, or is it someone's unwillingness to accept the fact we are not living in the economy of William Henry Harrison?

I feel quite sure that no one person probably holds all of the solutions to the problem that has given the liability insurance carriers so much concern. Many plaintiff's lawyers wonder also what consideration has been given by insurance companies to the views of such outstanding men among their own representatives as Mr. LaBrum, for example.

Lawyers who seek by a course of conduct over the years to deserve a reputation of honor and integrity at the bar and in the community seldom are given credit for an honest thought or a competent opinion as to the settlement value of a case. Only a small number or small percentage of practitioners, be they trial lawyers or otherwise, are men of little or no integrity, just as we like to think that most adjusters do not follow the practice reported in *Klettke v. Checker Cab Co.,* 168 N.E. (2d) 453 (Ill. App. 1960) and in noting this case, must be said candidly that it is seldom one encounters conduct of defense counsel that was condemned in that case. It is conceivable that some parts of this problem under review could be discussed with benefit to the insurance companies if representative heads of claims service could meet with an open mind with some of the top level trial lawyers at the plaintiff's bar qualified to speak for the latter group.

If the suggestion of Mr. LaBrum could be followed and diligent, thorough, competent investigation of claims were made, the phonies could be weeded out. Some of us like to believe that if the insurance companies would defend with vigor non-liability cases instead of making nuisance settlements with them, a form of legalized blackmail, they might find in the long run they were paying less money by far to defend the total number of their cases. A good way to educate the sort of lawyer who doesn't mind what cases he brings (if it's meritorious, that's only a coincidence) would be to teach him it is not economical to spend days in court hoping that the will of the wisp will lead him to the pot at the end of the rainbow. This, in the long run, would not only conserve dollars for the insurance company, but the energies of its trial lawyers and make available without inconvenience or hardship more dollars with which to settle the claims which are meritorious and in which there is real liability. It is difficult, if not impossible, however, to find any sympathy for anyone, whether he sells in-

surance or bananas, who does not take affirmative and realistic approaches to solve the problems that beset him.

To recapitulate the suggestions: (1) Thoroughly investigate claims; (2) Defend always where it is not clear there is liability; (3) Make realistic offers to settle liability cases before trial; and (4) Discuss the problem with those impliedly accused of impairing the solvency of the insurance industry.

James C. Baggott
Dayton, Ohio

November 1, 1960

In the INTERESTS OF JUSTICE

Court congestion and delay in disposition of civil litigation are matters of wide concern. In these columns will be printed reports of what is being done to combat these problems. Readers are invited to contribute information as to such activities in their own communities.

Streamlining and Expediting Justice by the Court and Trial Bar

HONORABLE WALLACE S. GOURLEY
Pittsburgh, Pennsylvania

IN connection with the judicial supervision of litigation, the following practice and procedure is applied in the administration of the United States District Court for the Western District of Pennsylvania:

A. *The Calendar*

The calendar for holding court and conducting other judicial duties is devised by agreement of the six judges with the advice of the clerk. It calendars the court year and contains the activities for all six judges. For 1960-1961, six one-week periods have been scheduled for arguments of motions; twelve weeks of pretrials; twenty-four weeks of jury trials (three judges trying criminal jury cases during six of such weeks) nonjury calendar, including admiralty, civil and criminal, five weeks; five weeks for opinions and other duties.

B. *Injunctions, Habeas Corpus, Statutory Court*

All injunctions, habeas corpus and statutory court proceedings are assigned among the members of the court on a rotation basis.

C. *Miscellaneous Judge*

One of the members of the court is designated as Miscellaneous Judge on the average of six to ten weeks each year. The judges, on a rotation basis assume these duties:

1. Hear and finally adjudicate all pleas of guilty in criminal cases.
2. Supervise and administer all naturalization, bankruptcy, and reorganization matters, including all applications for restraining orders, injunctions in bankruptcy and special naturalization matters.
3. Hear and determine all motions of a miscellaneous nature, motions to suppress, and all motions of an ex-parte nature.
4. Any other matter that would fall in the category of miscellaneous business.

Chief Judge WALLACE S. GOURLEY *has served as Chief Judge of the United States District Court for the Western District of Pennsylvania since 1951, and has been a member of that Court since December 17, 1945. The present complement of the court comprises six judges: Wallace S. Gourley, Chief Judge, Rabe F. Marsh, Joseph P. Willson, John L. Miller, John W. McIlvaine and Herbert P. Sorg.*

Chief Judge Gourley was graduated from Ohio State University in June, 1929; was admitted to the practice of all courts in Ohio in August, 1929; was admitted to practice in the Commonwealth of Pennsylvania in January, 1931; engaged in the trial of defense work from 1931 to 1936, and in the trial of both plaintiff and defense work from 1936 to 1945; was First Assistant District Attorney of Washington County, Pennsylvania, from 1936 to 1941; a member of the Senate of Pennsylvania from 1941 to 1945; and is presently a member of the National Pretrial Committee of the United States and a member of Committee Thirteen which comprises the Chief Judges of the multi-component United States District Courts in the thirteen metropolitan areas of the United States.

D. *Criminal Docket*

A criminal panel of three judges are designated three to five times a year to administer the trial of criminal cases. The first designated judge of the panel acts as the administrator of the criminal term and assigns the cases among the members of the panel. It has been our experience that three judges sitting seven to ten weeks a year can administer the criminal docket. A jury may be empaneled at any time to try a criminal case in which the accused is confined to jail unable to make bail. This is done also during all of the summer months. In view of this practice the criminal docket is current at all times.

E. *Civil Non-Jury Cases*

On the first of each month, civil non-jury cases in which an answer is filed and issues framed are divided by the clerk among the members of the court on a rotation basis. The clerk notifies the attorneys of record in writing and the case becomes the responsibility of the judge. Any order made by him is reflected on the daily minute sheet and entered on the docket and the 4 x 6 card and becomes a matter of public record. Upon being assigned a non-jury case, the trial judge immediately invokes pretrial procedure in which counsel are required to submit formal pretrial statements, stipulations, and mark exhibits prior to designated dates. All motions must be directed to the trial judge and appropriate entries made on the record card.

F. *Involved Civil Cases, Sherman Anti-Trust, Patent, and Contract Cases*

If an action falls into the category of Sherman anti-trust, patent, or involved and intricate contract suit, the clerk reviews the complaint with the Miscellaneous Judge and assigns the proceeding in seniority rotation to a member of the court.

The practice in these prolonged cases is to invoke the Prettyman report and/or the procedure outlined in the Handbook of Recommended Procedures for the Trial of Protracted Cases adopted by the Judicial Conference of the United States. Counsel are required to meticulously comply with the conditions therein provided, and are not permitted to pursue discovery or any other avenue of investigation without formal consent of the court, in order to avoid collateral and remote expeditions which might sidetrack the basic issues and unduly delay the trial date. The court exercises iron-clad control over these cases, from the date of their assignment to a judge to the date of their final disposition.

G. *Land Condemnation Cases*

These cases are divided among the judges equally. The judge appoints a commission of three persons to render the determination of compensation under Rule 71 (a) of the Federal Rules of Civil Procedure. One member must be a member of the bar, the chairman being designated in the order of appointment. The clerk submits a monthly report as to whether compliance has been made with the Order of Reference.

The practice is followed of giving Orders of Reference to the same judge as to all land which is situated within a given taking so that one Board of Commissioners is not appointed for a part of the taking by one judge, and another Board of Commissioners appointed by another judge on a taking that might be made subsequent to the original taking.

Within the past eight years, of a total of 609 land cases administered by commissioners, only in four instances were jury trials requested as to disputed questions of fact.

H. *Civil Jury Cases*

Under the Pretrial Rule of Court procedures are provided to move all civil jury cases to a Pretrial Civil Jury List, thence to the Master List of Civil Jury Cases for trial. (Exhibit A) Under this Rule, the court directs the clerk to invoke the Pretrial Rule in a minimum of fifty civil jury cases each month. Each month the Chief Judge, clerk and trial calendar clerk review the civil jury cards, selecting in numerical order, commencing with the oldest case, the number directed. A Pretrial Notice is sent by the clerk to the attorneys of record that such case is being placed upon the Pretrial Civil Jury List. (Exhibit B) The notice directs the attorneys to comply with all the provisions of said Pretrial Rule.

The steps which must be taken within the time schedules therein provided make it mandatory for the parties to complete discovery, make and dispose of all necessary motions, and make complete and unequivocal disclosure to each other of the evidence to be presented at the trial within 70 days after the clerk's notice. Within 90 days after the Pretrial Notice of the Clerk, counsel

must meet at a place mutually agreeable, confer on the legal and factual issues and the need for supplemental medical examination. At this time, they must stipulate in writing, matters not in dispute and mark documents either for admission into evidence or for identification. They are directed also to explore the possibilities of settlement. The pretrial conference statement and exhibits must be filed with the clerk and one week prior to the actual date of pretrial hearing, parties are directed to file briefs on disputed questions of law. A notice is sent to counsel for the parties which sets forth the date for Pretrial Hearing. (Exhibit C) This notice is sent two to four weeks prior to the date fixed for Pretrial Hearing.

The judge then orders the cases on which pretrial is concluded to be placed on the Master Civil Jury List for the next term.

He indicates on involved contract cases he pretries (and may do so in involved negligence or other cases) that he will try the case, but these latter cases take their place in numerical order along with the other cases on the Master Civil Jury List. They are marked on this list with the judge's name. The clerk gets this information as to which cases are to go on the Master List from the daily minute sheet. A minimum of 200 to 250 pretried cases must appear on the Master Civil Jury Trial List. If, by reason of settlements or other breakdown, it appears that pretried cases are needed for the next Master Civil Jury Trial List, the clerk arranges with judges and lawyers to have additional cases pretried by the judges before the trial term.

Pretrial hearings are held twelve weeks a year and with the standardized practice adopted each judge can thoroughly supervise the pretrial of 25 to 40 cases a week.

Great difficulties were encountered when the rule was first invoked. It was difficult to enforce time schedules, which the lawyers often ignored, by reason of their natural laxity and because the concentration of negligence cases in the hands of a few made it impossible for the lawyers to ready cases for the full discovery and other procedures involved.

The rule itself provides for penalties and sanctions. These are at the discretion of the judge, and include dismissal of plaintiff's cause of action, permission to proceed ex-parte, and barring defendants from offering testimony. If all parties fail to comply, the action may be dismissed. Motions for continuance, extension of time and postponement are heard by the Miscellaneous Judge, but sanctions are administered by the pretrial judge. Where a continuance is requested, the court can refer to the record card which summarizes all matters and actions pertaining to the case, and be in a position to know instantly whether the case has experienced undue delay.

The clerk is directed to bring defaults to the attention of the Miscellaneous Judge and to extend his efforts in keeping the lawyers meeting deadlines. To facilitate such constant checking, an assistant has been put in charge of these procedures and, to systematize his work, a device has been installed whereby the clerk can immediately be apprised of any derelictions and can note action taken to compel compliance.

I. *Selection of Juries*

On the Friday before the Monday that the Civil Jury Term begins, jurors are required to report, at which time juries are selected under the supervision of the clerk to serve each member of the court the following Monday. A judge is not present but the Miscellaneous Judge makes decisions on any dispute that arises with a court record in the selection of each jury. If a panel of six judges is to be engaged in trying cases for the beginning of the jury term, ten juries are selected on the preceding Friday and counsel alerted to be ready to select four additional juries on the Monday morning of the beginning of the jury term. Thus, fourteen juries are available and ready to proceed on the day the trial term commences.

It has been the general experience that at least half the cases, where standby juries are selected, are settled by the time the trial term commences.

With three members of the court sitting as Criminal Judges, practice likewise is followed of selecting five standby juries on the preceding Friday and counsel alerted to select three additional juries on Monday morning of the beginning of the criminal jury term. By the time the criminal trial term commences, the general experience has been that approximately 75 percent of said cases are changed to pleas and their need for administration by jury trial no longer exists.

In order to make certain that judicial manpower is constantly in use, three standby juries are always held in readiness to feed to judges whose trials are concluded, settlement effected, or where a courtroom has become available for any other reason.

J. *Administrative Supervision*

Judges are designated by rotation to be responsible for the operation of divers administrative offices under the supervision of the court. For example, a judge will supervise the probation office, referees in bankruptcy, court reporters, etc. In this way each judge knows the many problems that arise from day to day in each agency or department under the court's supervision. In addition, the chief judge maintains a daily check on the operation of the office of the clerk of Courts to make positive cases keep moving as the manpower of the court will permit.

A meeting of the Board of Judges is held each month where all matters are considered which have been presented to each judge under his administration. All decisions are finally made by the Board of Judges. A detailed record is kept and maintained by the Board of Judges.

K. *Certification of cases for trial solely as to the question of liability where substantial dispute exists*

It has been our experience where multiple plaintiffs or defendants are involved in the same proceeding or similar proceedings which are consolidated for trial and a substantial dispute exists between some or all of the parties as to liability or responsibility for the plaintiff's claim, the aspect of the proceeding which relates solely to liability is first submitted to the jury with no evidence to be offered as to damages. If liability is found to exist, the same jury is then used in the determination of damages as to the parties where liability is found to exist.

We find that by this practice being followed many cases are settled after the liability is determined. The trial is thereby simplified, doctors need not be alerted and a substantial saving of time arises both as to counsel for the parties and the court.

L. *Certification of Factual Issues as to Diversity of Citizenship and Jurisdictional Amount*

It has been the experience of our court in cases where the diversity of citizenship of a party is in substantial dispute or jurisdictional amount is questioned, that considerable time of trial counsel and the court is saved if the question of diversity of citizenship and/or jurisdictional amount is first submitted to the jury under appropriate instructions from the court.

The United States Court of Appeals for the Third Circuit has ruled in the case of *Seideman v. Hamilton,* 275 F. 2d 224, that the factual issues as to diversity of citizenship may either be presented to a jury or reserved by the trial judge for resolution and decision.

It is my judgment where this question is posed where a jury trial has been requested for the determination of the issues, that the issue of diversity should be submitted to the jury. It is my further judgment that the same rule of law should have application to the jurisdictional amount.

If the issue of diversity of citizenship and/or jurisdictional amount is resolved in favor of the plaintiff, the same jury is used for the determination of all other issues in the proceeding.

This practice has saved considerable time and effort on the part of the trial bar and the court, many cases are settled after the determination of the issue, and it has proved invaluable in the administration of the affairs of our court.

Conclusion

The practical application of this procedure in civil jury cases indicated less than ten percent result in verdict or judgment. A breakdown as to when cases are finally adjudicated reflects the following:

Cases disposed of after Pretrial Rule of Court is invoked	40%
Cases terminated after pretrial hearing is held	10%
Cases terminated when attorneys are told to make ready to select a jury	10%
Cases terminated after standby jury is selected by the attorneys who are waiting for a judge to try the case	13%
Cases settled and terminated after the trial has commenced	19%
Cases which went to jury verdict	8%

On June 1, 1958, at the time of the adoption of the standardized pretrial procedure, 2195 civil cases were pending, necessitating a delay of three to four years for the disposition of cases. By virtue of an unceasing and relentless application of this procedure, requiring in flagrant cases the imposition of sanctions, penalties, fines and dismissals on dilatory and noncomplying counsel, this backlog has undergone a reduction to 1342 cases on November 1, 1960, with the present period of the filing-to-trial date reduced to approximately two to two and one-half years.

Considerable time is saved the court and trial counsel if at the time settlement is negotiated counsel for the parties execute a stipulation in order that the proceeding can be removed from the court's docket. Prior to this practice, considerable delay resulted since counsel were required to return to their office, prepare the stipulation and find a suitable time for its execution. Therefore, the practice presently followed by our court is for the clerk to have on hand a mimeographed stipulation form which could very easily, without any great limitation on a judge's secretary, be prepared at the time that a settlement is reached, which counsel signs in the presence of the judge and an appropriate order is entered.

The methods in vogue have proved invaluable toward the speedy and expeditious administration of the court's docket and have made it possible to keep pace with and, at certain periods, to exceed the current rate of filing suits in this district.

* * *

EXHIBIT A

PRE TRIAL ORDER

AND NOW, this 15th day of May, 1958 as provided by Rule 38 of the United States District Court for the Western District of Pennsylvania, Rule 5 (II) PRE TRIAL PROCEDURE as now effective is hereby revoked, and in lieu thereof said Rule is to provide as follows effective forthwith:

A. There will be a pre-trial on every civil case, unless counsel for the parties stipulate in writing to the contrary and approval is given by the Judge. The Clerk shall set apart from time to time a list of cases to be known as the Pre-trial Civil Jury List. Cases shall be added to this list as directed by the Court.

B. Non-jury cases shall be pre-tried in accordance with an Order by the Judge to whom the case has been assigned.

C. In all civil jury cases involving personal injuries, the following pre-trial procedures are invoked and shall apply on written notice to counsel of record by the Clerk that a case has been placed upon the Pre-trial Civil Jury List.

1. All discovery including medical examinations, which is authorized by the Federal Rules of Civil Procedure shall be completed within 50 days after a case is placed on the Pre-trial Civil Jury List. Additional medicals will be allowed but only upon Order of Court or written stipulation of the parties. Any other supplemental discovery or extension of time may only be granted after written motion and Order of Court.

2. Within 60 days after a case has been placed on the Pre-trial Civil Jury List, counsel for the Plaintiff shall serve a narrative written statement of the facts that will be offered by oral or documentary evidence at trial upon all counsel of record and file a copy with the Clerk of Courts. There shall be attached to said written statement:
   (a) Medical reports of any doctor who treated, examined, or has been consulted in connection with the injuries complained of.
   (b) Names and addresses of all witnesses the Plaintiff expects to call. Said witnesses shall be classified as liability, medical or condition witnesses.
   (c) Written authorization to inspect hospital records where plaintiff may have been examined, treated or hospitalized.
   (d) The written statement shall include a list of the damages that the plaintiff intends to claim and prove at the trial.

3. Within 70 days after a case has been placed on the Pre-trial Civil Jury List, counsel for the defendant shall serve a narrative written statement of the facts that will be offered by oral or documentary evidence as a defense at trial upon all counsel of record and file a copy with the Clerk of Courts. There shall be attached to said written statement:
   (a) Medical reports of any doctor who treated, examined, or has been consulted in connection with the injuries complained of.
   (b) Names and addresses of all witnesses the defendant expects to call. Said witnesses shall be classified as liability, medical or condition witnesses.

4. Within 80 days after a case has been placed on the Pre-trial Civil Jury List, counsel for the third party defendant shall serve a narrative written statement of the facts that will be offered by oral or documentary evidence at trial upon all counsel of record and file a copy with the Clerk of Courts. There shall be attached to said written statement:
   (a) Medical reports of any doctor who treated, examined, or has been consulted in connection with the injuries complained of.
   (b) Names and addresses of all witnesses the Third Party Defendant expects to call. Said witnesses shall be classified as liability, medical, or condition witnesses.

5. Within 90 days after a case is placed on a Pre-trial Civil Jury List, counsel for the parties shall confer and consult at a place found mutually convenient to all concerned.
   (a) Counsel for the parties shall consider the factual and legal issues involved and agree to supplemental medical examinations if necessary, and shall stipulate in writing as to all matters which are not in substantial dispute.
   (b) Counsel shall mark all documents and note on each whether the exhibit may be admitted into evidence by stipulation. If not admitted, they shall be marked only for identification. A list of all exhibits shall be submitted to the Court at pretrial. Exhibits shall be made available for copying by opposing counsel.
   (c) Counsel shall explore the possibility of an amicable settlement and are requested to consult with their clients prior to the conference in order that they shall have authority to compromise the case if a settlement is possible.
   (d) Trial counsel must attend the conference and the pretrial.

6. One week prior to the actual date of pretrial counsel for the parties shall file with the Court a brief on any disputed question of law.

D. The procedure outlined in paragraph C, insofar as applicable shall be followed in all civil jury cases, but a Judge may provide a special pretrial procedure in any case assigned to him.

E. The Judge, shall cause a record to be made of the facts and matters agreed upon at the pretrial conference. The record of the pretrial shall be deemed the pretrial order, except that the Judge may enter a separate order. The Court may compel agreement as to undisputed facts. Counsel must object to or be deemed to have accepted the pretrial record and any order of the Judge entered therein.

F. The Court, at the pretrial conference, may consider motions to continue, to amend, to consolidate, or to sever.

G. Failure to make a full disclosure of evidence during the Pretrial Conference will result in exclusion of that evidence at that trial. The only exceptions will be (1) matters which the court determines were not discoverable at the time of the pretrial conference, (2) impeaching matter, and (3) privileged matter. Insofar as impeaching or privileged matter is known at the time of the pretrial it must be disclosed to the Court alone, for determination by the Court as to the requirement of disclosure.

H. When a case is listed for pretrial, it shall not be continued except for just cause. If there is a failure to comply with the pretrial rules, the Court may effect such penalties and sanctions as in the judgment of a judge the circumstances warrant, which may include the dismissal of the Plaintiff's cause of action, or the granting of permission to proceed ex parte and barring any defendant who fails to comply, from offering any testimony. If all parties fail to comply the action may be dismissed.

I. At the Pretrial Conference, the Court may inquire as to the possibility of settlement. Any discussion pertaining to settlement shall not be a part of the pretrial order not be permitted to be used in the trial of the case of any arguments or motions relating thereto.

* * *

EXHIBIT B

PRE TRIAL NOTICE

(Name and address of counsel)

Dear Sir:

Please be advised that the above entitled case has been placed upon the Pretrial Civil Jury List. You are, therefore, directed to comply with the provisions of New Local Rule 5 (II), as adopted by the United States District Court for the Western District of Pennsylvania on May 15, 1958.

It is now an Administrative Ruling of the Court that all Attorneys are required to file the written stipulation as to facts not in dispute, as provided by Local Rule 5 (II) C-5 (a) and the list of exhibits required under Rule 5 (II) C-5 (b) with the Clerk of Courts at least 10 days prior to the date fixed for Pretrial Conference.

After the time limitations set forth in Rule 5 (II) for the completion of Pretrial procedure, this case is subject to be set for a Pretrial Conference before a member of this court. In due course, you will receive a notice giving you the date, time and name of the Judge for Pretrial Conference. Every effort will be made to give counsel at least 14 days notice of the Pretrial Conference.

(Signed by the Clerk)

* * *

EXHIBIT C

Re:
Civil Action No.....

Dear Sir:

A PRETRIAL CONFERENCE Will be held on ..... the ..... day of ..... 1960, at ..... o'clock ..... M., before the Honorable .....in Room No..... This case will not be continued except for just cause, promptly requested. In order for the pretrial to be effective, the court requests that you adhere to the following:

1. Trial counsel should be present. Rule 511 (b), Rules of Court, W. D. Pa.
2. Counsel should be able to state orally the details of evidence to be presented upon disputed facts.
3. Counsel should have available all exhibits or documentary proofs which may be offered at trial.
4. Counsel should be able to state the issues of law involved. Trial briefs on any unusual issue of law may be offered at pretrial and are solicited.
5. Counsel should be able to speak with finality on all questions. It is suggested that parties litigant (or authorized claim agents) attend pretrial.

Your cooperation in the foregoing will be appreciated.

(Signed by the Clerk)

From the Dade County Grand Jury Report*

THE HIGH COST OF AUTOMOBILE AND OTHER LIABILITY INSURANCE AND THE RELATIONSHIP OF UNETHICAL ACTIVITY THERETO

THIS Grand Jury returned an indictment against James Joseph Martin and Paul Joseph O'Grady, charging them with attempted grand larceny in connection with the filing of a fraudulent claim against an insurance company seeking damages for injuries alleged to have been sustained from falling in a Miami five and ten cent store. This indictment climaxed months of intensive investigation by the office of the State Attorney. The investigation revealed that the two defendants placed candy bars on the staircase leading from a restaurant on the mezzanine floor to the ground floor, then walked down the staircase, stepped on the candy bars and simulated an accidental fall. They both feigned personal injuries and filed claims against the store which were turned over to the insurance carrier.

It was also disclosed by the investigation that one of the claimants had collected on several similar claims in other parts of the country and that the alleged fall was a deliberate act on the part of the two claimants to defraud the insurance company. Both defendants pleaded guilty to these charges, the ring leader was sentenced to one year in the State Penetentiary, and the other defendant being a first offender, was placed on probation. Richard E. Gerstein, State Attorney, and his staff are to be commended for the excellent manner in which this case was handled, as well as Judge George E. Schulz, who recognized the seriousness of this type of crime and its impact upon the community, in passing sentence on these culprits.

The above incident highlighted the existing problem of false and fraudulent insurance claims in Dade County.

The Grand Jury made an extensive investigation into this matter, hearing witnesses representing the various interests involved—attorneys, insurance company executives and investigators, doctors, etc. The most serious aspect of this problem is the effect it has upon premium rates for automobile and other liability insurance in Dade County. False and fraudulent claims, excessive jury verdicts, exorbitant doctor and hospital bills, and padded automobile repair bills are a direct cause of high insurance rates. Despite popular belief to the contrary, the occasional hundred thousand dollar jury verdict is not the primary cause of high premium rates for insurance. However, these high verdicts influence the settlement of small claims in that the claimants demand more than they would have previously. Threat of suit causes insurance companies to settle claims that should be resisted.

Fringe operators in the legal and medical professions are guilty of unethical practices which largely contribute to this problem. Fortunately, they represent only a small number in both professions.

The problem which exists is one of ethics and not of law enforcement. It can be solved only through the concerted efforts of the Florida Bar and Florida Medical Association in cooperation with the local Bar and Medical Associations.

The procedure of the Florida Bar for handling complaints against lawyers charged with unethical practices is slow and cumbersome. The procedure for revocation or suspension of doctors' licenses for unethical practices is archaic and outmoded. Both procedures should be corrected by remedial measures of the State Supreme Court and the Legislature.

Ambulance chasing engaged in by fringe lawyers could be eliminated if the people of this county would refuse to employ lawyers who directly or through others solicit their cases. The solicitation of law suits is prohibited by the Code of Ethics and usually is engaged in by lawyers whose incompetence results in injury to the cause of their clients.

Testimony before the Grand Jury reveals that the greatest loss to the insurance companies occurs in those cases where claims are made and paid off in the under $1000 bracket. Doctors and lawyers are not always involved in this type of claim. The general public frequently makes excessive

*Editor's Note: Two sections of the Report filed November 8, 1960 by the Grand Jury of Dade County, Florida, are printed for the information of our readers and to demonstrate the public concern about automobile accidents and litigation resulting therefrom.

claims for relatively minor damage and injury and insurance companies settle for the "nuisance value." The Grand Jury recommends strongly that insurance companies expend more effort in investigating claims, no matter how small they may be. Resisting the fraudulent claim is a necessity if premium rates are ever to be reduced.

Insurance companies are a regulated industry and are governed by the laws of the State of Florida. However, the rate fixing provisions of such laws should be repealed as price fixing is contrary to free enterprise and the American way of life. Price fixing of insurance rates in effect is an ex parte procedure in which the people are not represented and have no voice.

Dade County is a large, densely populated urban area with the added traffic hazards caused by thousands of visiting motor vehicles. Statistics disclose a greater percentage of accidents, more claims for personal injury and property damage, and higher verdicts in large urban areas. Dade County cannot expect automobile and other liability insurance premium rates to be as low here as in other parts of the state, but if corrective measures are taken as herein pointed out, this problem can be alleviated.

Recommendations

We recommend:

1. The establishment of an investigative office in Dade County by the Florida Bar to investigate complaints of "ambulance chasing" and other unethical activity and make their findings available to the local Grievance Committees of the Bar.
2. That the statute governing the revocation or suspension of the right to practice medicine be enlarged so that it will encompass many improper activities not now included.
3. That a more vigorous effort be made by the various police departments and the hospitals to stop their employees from soliciting accident victims for certain attorneys and doctors, in violation of state law, and that all such violations be vigorously prosecuted.
4. An organized county-wide continuing educational program utilizing every form of media to alert the public to the problems of traffic safety and reduce the incidence of accidents.
5. Separation of the offices of State Treasurer and Insurance Commissioner and the creation of a Department of Insurance headed by a Commissioner with no other responsibilities.
6. Rate fixing provisions of the insurance laws of the State of Florida should be repealed and the fixing of insurance premium rates left to competitive free enterprise, or in the alternative:
   (a) That the Insurance Commissioner publicize requests for increased insurance rates and that a public hearing be held before any decision is made increasing such rates.
   (b) That the Commissioner employ more statisticians so that rate fixing can be based on the Insurance Department's own figures rather than those submitted by the insurance companies.
   (c) That the Attorney General of the State of Florida be delegated by the State Legislature with the responsibility of representing the people of this State at such public hearings.

TRAFFIC SAFETY

This Grand Jury became concerned over the rising death rate from motor vehicular accidents in the streets and highways of our community. Previous Grand Juries have examined this field and have made their recommendations. We felt it our duty to investigate one facet of this death rate, that is, the effect of alcohol and drugs upon the drivers of motor vehicles involved in fatal accidents.

From the statistics furnished by the Dade County Medical Examiner's Office, we learned that alcohol was a major factor in more than fifty percent of the fatal traffic accidents which occurred in our area. At the present time, various machines and equipment exist for the testing of the amount of alcohol in a person's system. The two major methods of testing the amount of alcohol a person has in his system are by an examination of either his breath or his blood. Our courts permit the introduction of the results of the examination of either a person's breath or examination of the blood stream as corroborative evidence, that is evidence which tends to support the arresting officer's opinion. When the machinery for testing the breath

was first introduced, our courts required a very high reading on the machine before it would suffice for conviction. This requirement of a high reading on the machine persists in the decisions of most of the courts in our area today.

Considering first those cases not involving manslaughter, the law is that a person should not operate his motor vehicle while under the influence of alcohol to the extent that his normal faculties are impaired. Under the high test as previously mentioned, a person of average height and weight would have to have in his system six ounces of 100 proof whiskey or a reading on the machine which examines the breath of .150 percent to sustain a conviction.

Considering secondly the law on manslaughter, a defendant to be guilty of manslaughter by reason of driving under the influence of alcohol must be intoxicated. The average driver would have to have approximately nine ounces of 100 proof whiskey or its equivalent in his system, which would attain a reading on a machine designed to test the breath of .220 percent, in order for this evidence to be introduced and sustain a conviction.

From the evidence gathered by this Grand Jury we beileve these standards are too high. In 1957, for example, 67 percent of the drivers killed in automobile accidents showed the presence of alcohol in their systems when tested. Under our present laws, 43 percent of those killed would not have been guilty of driving while under the influence of alcohol, and 75 percent would not have been guilty had they been tried for manslaughter. From the figures gathered this year, at the time of our investigation, some 55 percent of the drivers at fault and involved in traffic fatalities had been drinking. Of this number 39 percent of the drivers tested, who were at fault and had been drinking, would have been acquitted of driving while under the influence of intoxicating beverages. These figures indicate a consistency or correlation between the 1957 figures and the figures to date this year.

From the medical testimony the Grand Jury received, it is the opinion of experts that a person's normal faculties become impaired after having consumed far less alcohol that is presently required by our courts. It is also their opinion that a person becomes intoxicated after having consumed fewer drinks than is presently required for the evidence from the machinery to sustain a conviction in our courts. In addition to the expert testimony, experiments were conducted in the Grand Jury's presence which substantiated the opinions of the experts.

In addition to the evidence gathered in the alcoholic driver field, the Jury also examined the law and received testimony concerning those persons driving while under the influence of drugs. At the present time, our law in the non-manslaughter cases is limited to those persons driving while under the influence of alcohol or narcotic drugs. In this day of medical and chemical advancement, many medicines and drugs are on the market which cause an intoxicating effect on people. However, these new drugs are not considered narcotics. It is our opinion that the law in this regard should be changed so that a person who operates a motor vehicle while under the influence of any beverage, drug or substance to the extent that their normal faculties become impaired should be found guilty and not just those persons who have been taking narcotic drugs or drinking alcoholic beverages. In regard to manslaughter cases, the law is void for all causes save intoxicating beverages. We believe the law in regard to manslaughter cases should be changed to include intoxication as a result of drinking alcoholic beverages, taking narcotic drugs, or any other substance which produces an intoxicating effect on the human being.

Our concern over the increasing traffic toll in Dade County convinces this Jury that all persons who are stopped upon our highways and who in the opinion of the arresting officer have been drinking or taking some intoxicating drug should be required to take a test to determine the amount of alcohol or intoxicating drug in their systems. This is the so-called "Implied Consent Doctrine." That is, our courts have ruled that it is a privilege to operate a motor vehicle on the streets and highways of our state. Therefore, the law should be that a person when he drives on these streets and highways impliedly gives his consent to the taking of these tests. Several states have already adopted such a law. We strongly urge that our State Legislature adopt a similar statute.

To safeguard the public, the Legislature may desire to set up a separate office of the government to administer the test, whether they be by a drunkometer machine or by testing a sample of the driver's blood. In any event, the number of cars on our exist-

ing highways, the miles travelled by all persons on the road, points to the need for strict law enforcement over all facets of traffic safety and demands that the unsafe driver be eliminated from our roads.

Recommendations

We recommend:

1. That the State Legislature pass a statute requiring that automobile drivers be required to take a test to determine the amount of alcohol or intoxicants in their blood streams under the so-called "Implied Consent Doctrine" or forfeit their drivers' licenses.
2. That the Legislature adopt a standard for determining at which point all persons will be considered as having their normal faculties impaired.
3. That in setting this standard, the State Legislature consult the American Medical Association and other experts in determining what that standard should be.
4. That the law be changed whereby the results of such tests be primary evidence of the driver's impairment rather than mere corroboration of the arresting officer's opinion as is the case at the present time.
5. That the law be changed so that a person will be found guilty of operating a motor vehicle while his normal faculties were impaired for any reason.
6. That in manslaughter cases the test for intoxication be similarly reduced in line with the opinion of the American Medical Association and other experts.
7. That the law in manslaughter cases be expanded to include any substance which results in an intoxicating effect upon a human being and not just alcohol.
8. That all traffice safety rules should be vigorously enforced for the protection of all citizens of our community.

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Wisconsin Repudiates Unit-of-Time Argument

"Pain and suffering has no market value. It is not bought, sold, or bartered. It has no equivalent in a commercial sense." So says the Supreme Court of Wisconsin in ruling that the proper scope of jury argument does not include the use of a mathematical formula to measure pain and suffering on a unit-of-time basis.[1]

In the opinion of Judge Hallows, it is shown that plaintiff's counsel gratuitously allocated $1.50 per day to the value of the plaintiff's pain resulting from an injury to the plaintiff's arm. Counsel multiplied $1.50 by 365 days and then multiplied that sum by twenty, which was the life expectancy of the plaintiff in years. This was held to constitute prejudicial error,[2] and the case was reversed for a new trial on the issue of damages only.

In a very well-considered opinion, Judge Hallows cites *Botta v. Brunner*,[3] *Faught v. Washam*,[4] *Certified T.V. and Appliance Co. v. Harrington*,[5] *Henne v. Balick*,[6] and several other reported cases.[7] After noting that there are decisions pro and con on this subject, the opinion asserts:

> "We believe that the arguments advanced disapproving the use of a mathematical formula are more persuasive. The use of a mathematical formula is pure speculation by counsel, which is not supported by the evidence and presents matters which do not appear in the record. The formula may be used to arrive at a gross figure by taking an arbitrary amount of money per day and multiplying it by the number of days in a year, times the number of years of the life expectancy of the plaintiff. Logically, if this method were followed, the gross amount arrived at should be discounted to its present worth. Seldom is pain constant for the entire life expectancy of the plaintiff, and if the evidence showed that it would be, the intensity of pain normally varies. It is true the formula can be tailored to fit the evidence in cases where pain is sporadic or intermittent, by taking into account only the number of days which the evidence shows future pain might be suffered. This use of the formula is still subject to the basic criticism that the formula must always include an arbitrary dollar amount per day or other period of time, which has no foundation in the record. It is argued that the per diem amount of money is relatively so small that it is obviously reasonable. Such an argument begs the question. The fact is such amount or valuation is not in the evidence and, indeed, could not be."

The court then proceeds to discuss the method of application of such a mathematical formula, and says:

> "There is no mathematical way of formulating a formula which will represent all the varying factors involved in pain and suffering in a given case without making assumptions of fact which are not in the evidence. The formula, rather than being an aid as claimed, would result in confusing the jury. The basic reasoning behind the use of any mathematical formula is not so much to aid, or even to persuade, the jury as it is to ultimately establish a fixed standard to displace the jury's concept of what is a fair and reasonable amount to compensate for the pain and suffering sustained as shown by the evidence in the light of the common knowledge and experience possessed by the jury of the nature of pain and suffering and the value of money.
>
> "The difficulty in using a mathematical formula to measure damages for pain and suffering is inherent in the nature of pain and suffering. It cannot be measured by any such mathematical standard. Pain and suffering has no market price. It is not bought, sold, or bartered. It has no equivalent in a commercial sense."

The "absurdity of a mathematical formula" is demonstrated by Judge Hallows as follows:

> "The absurdity of a mathematical formula is demonstrated by applying it

[1] *Gladys Affett v. Milwaukee & Suburban Transport Corp.*, Case No. 41, August Term, 1960, decided by the Supreme Court of Wisconsin November 29, 1960, motion for rehearing pending.

[2] See also *Hamilton v. Reinemann*, 233 Wis. 572, 582, 290 N.W. 194.

[3] 26 N.J. 82, 138 A. 2d 713, 60 A.L.R. 2d 1331.

[4] 329 S.W. 2d 588 (Mo.).

[5] 201 Va. 109, 109 S.E. 2d 126.

[6] 146 A. 2d 394 (Del.).

[7] See also 25 Ins. Counsel J. 388 and 60 A.L.R. 2d 1347.

to its logical conclusion. If a day may be used as a unit of time in measuring pain and suffering, there is no logical reason why an hour or a minute or a second could not be used, or perhaps even a heart beat since we live from heart beat to heart beat. If one cent were used for each second of pain, this would amount to $3.60 per hour, to $86.40 per twenty-four-hour day, and to $31,536 per year. The absurdity of such a result must be apparent, yet a penny a second for pain and suffering might not sound unreasonable. The principle is the same, whether one uses a second, an hour, or a day as the basic unit of time, because to the unit of time used one must assign some money value which has no foundation in the evidence. We see no difference in using the mathematical formula for illustrative purposes and using it to determine the reasonableness of the amount sought as damages. The use of the formula was prejudicial error."

Finally, this excellent opinion refers to the right of counsel to state and argue the amount of future pain and suffering that he believed the evidence would fairly and reasonably sustain. On this point Judge Hallows says:

"The amount cannot be referred to as the amount in the *ad damnum* clause. The *ad damnum* clause has no probative value and is no part of the evidence. It is common knowledge that the *ad damnum* clause is the equivalent of the asking price and is inserted in the complaint before any evidence is in the record.

"Counsel for both the plaintiff and the defendant may make an argumentative suggestion in summation from the evidence of a lump sum dollar amount for pain and suffering which they believe the evidence will fairly and reasonably support. Counsel may not argue such amount was arrived at or explained by a mathematical formula or on a per-day, per-month, or any other time-segment basis."

Thus another court of last resort has recognized that the determination of damages for pain and suffering is not susceptible of arithmetical calculation, and has refused to permit an argument grounded on a unit-of-time basis calculated to secure from a jury a verdict much larger than that warranted by the evidence.[8]

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[8]See 27 Ins. Counsel J. 13.

The Handling of Contract Bond Claims*

ROBERT R. HUME
New York, New York

MOST surety companies write performance and payment bonds for contractors on a nationwide basis. Problems may therefore arise in any part of the country; and when they do it is a fortunate home office that has a competent, experienced field attorney in the area of the trouble available to jump in and give assistance.

In recent years, as a growing number of companies have expanded into multiple line underwriting, the need for knowledgable counsel in the locality of trouble has increased greatly. The practice of suretyship law is rewarding both for the challenge of the problems presented and the financial returns it brings to the able.

The handling of contract bond problems is not a field for the faint-hearted; for there is no standard operating procedure that can be relied upon in all or even most cases. A major guide to conduct will be an awareness of the general philosophy of the company you represent. Today, most surety companies are committed to the principle that the surety has a responsibility to the owner to get the work done with dispatch so that the obligee of the performance bond may obtain the performance he bargained for. The preferable manner of accomplishing performance may be arguable, but not our responsibility to act promptly.

Most surety companies, today, are also committed to the principle that obligees under the payment bond are entitled to be paid in full, no more, no less. No moral justification exists, in my opinion, for offering less than 100% of the amount due with the view perhaps that the claimant might take less in order to avoid a law suit. We should, of course, not pay a penny which we do not owe, but when we have determined the amount owing we should pay it in full—and promptly.

How, then, does one go about handling contract bond problems? There is no magic formula and there may be varying opinions among men of equal experience. I can but outline for you some of the fundamentals we observe in our company and some of the procedures we employ.

ROBERT R. HUME *has been Secretary and General Counsel of Seaboard Surety Company since February 1, 1958. He served nineteen years with American Surety Company before joining Seaboard in 1952. A graduate of St. John's University with an LL.B. from St. Lawrence University, Mr. Hume is admitted to practice in New York, in the Federal Courts, in the Court of Claims and in the Supreme Court of the United States. He is a director of Unity Fire & General Insurance Company and holds memberships in the New York State Bar, American Bar Association, Phi Delta Phi and IAIC.*

At the outset, as in every law case, it is essential to have a clear understanding of the nature of your obligation. The basis of the obligation is the bond, a contractual commitment on the part of the surety.

In public work, the bond will usually be drawn on a standard form supplied by the public body for which the work is being done. On federal jobs—except Capehart Act housing jobs—bonds are required by the Miller Act (40 U.S.C. Section 270a). On Capehart Act jobs, bonds are provided for by 42 U.S.C. Section 1594. The standard forms of bonds required under the Miller Act and the Capehart Act are supplied by the General Services Administration.

On state jobs, virtually every state has enacted legislation requiring contractors on public work to furnish surety bonds. The extent of these requirements, the coverage of the bonds and the interpretation of their provisions, are matters of state law.

On private jobs, and on subcontracts in connection with both public and private jobs, there are no standard forms. Regrettably, with such bonds being prepared by individual owners, prime contractors and surety companies, a myriad of forms are extant and in use. Perhaps the most commonly used forms on private work are those

*Presented before the Insurance Section of the Tennessee Bar Association at Gatlinburg, June 9, 1960.

recommended by the American Institute of Architects.

The Miller Act provides that "Before any contract exceeding $2,000 in amount, for the construction, alteration, or repair of any public building or public work of the United States is awarded to any person, such person shall furnish to the United States ***(1) A performance bond***for the protection of the United States" and "(2) A payment bond***for the protection of all persons supplying labor and material in the prosecution of the work provided for in said contract."

The amount of the performance bond is in such amount as is deemed adequate by the officer awarding the contract. The amount of the payment bond depends upon the contract price beginning with 50 percent thereof where the price is not more than $1,000,000; dropping to 40 percent of the contract price for contracts between $1,000,000 and $5,000,000; and reaching a ceiling of $2,500,000 where the contract price exceeds $5,000,000.

While the language of the Miller Act says that the payment bond is "for the protection of all persons supplying labor and material in the prosecution of the work" there are limitations. Only those workers, materialmen and subcontractors who deal directly with the prime contractor or with a subcontractor of the prime contractor may bring suit on the payment bond. (See *United States v. Frederick Raff Co.*, 271 F. 2d 415 (1959); *United States v. Blount Brothers Construction Co.*, D. C. Md., 168 F. Supp. 407 (1958), and, most recently, a case in the Fifth Circuit, *E. E. Elmer v. United States Fidelity and Guaranty Company*, decided February 29, 1960, 275 F. 2d 89—all to the effect that a Miller Act payment bond does not cover a person furnishing labor or material to a sub-subcontractor. And the United States Supreme Court has held that the surety on a payment bond is not liable to one who has supplied material to a materialman who contracted directly with the contractor, on the ground that a supplier of materials is not a "subcontractor" within the meaning of the Miller Act. *(MacEvoy v. U. S. of America for the use of Colvin Tomkins Co.*, 322 U. S. 102; 64 S. Ct. 890 (1944)).

Under the provisions of the Miller Act, those who deal directly with the prime contractor do not have to give any notice of their claims. Certainly he knows with whom he has dealt directly, and the extent of his indebtedness to them. But those people who furnish labor or materials to subcontractors do not have a right to sue under the payment bond unless they have given written notice to the contractor within ninety days from the date on which the claimant last did work or furnished material.

In *U. S. to use of John A. Denie's Sons v. Bass*, 111 F. 2d 965 (1940), it was held that this statutory provision for notice is without ambiguity and that in the absence of such notice an action may not be maintained under the bond. A recent amendment to the Miller Act provides that no suit shall be commenced under it after the expiration of one year after the day on which the last of the labor was performed or material was supplied. (40 U.S.C. Section 270b). There is, however, a noticeable tendency toward liberal construction where knowledge appears to be present, even if provisions regarding notice were not complied with. See *Dover Electric Supply Co. v. Leonard Pevar Co.*, 178 F. Supp. 834 (D. Del., 1959) where a supplier to a subcontractor sent timely notice of claim to the prime contractor but erroneously named a Delaware corporation of the same name as the corporation he had actually supplied—a New York corporation. It was held that the notice was sufficient since the prime contractor knew who his subcontractors were and, after getting notice, could regulate his payments to the subcontractor.

In a very recent case, decided November 9, 1959, by the United States Court of Appeals for the Tenth Circuit, *McWaters and Bartlett v. General Casualty Company of America*, 272 F. 2d 291, a liberal interpretation of the notice requirement was given. In this Miller Act suit, the claimant, two different times, displayed to the prime contractor an itemized statement of the labor and material furnished to the subcontractor and the amount due. The prime contractor, on one occasion, was alleged to have promised the claimant he would withhold the amount due the claimant from moneys due to the subcontractor. Pointing out that while the Miller Act provides for "written notice" it does not prescribe any particular form, the court held that it was unnecessary for the contractor to have the writing in his hand. "If he saw it and knew its contents, that was sufficient".

Similarly, the provision has been liberally construed in the Fifth Circuit, *(Coffee et al., v. United States, for use and benefit of Gordon*, 157 F. 2d 968 (1946); *Houston Fire and*

Casualty Insurance Co. v. U. S. to use of Trane Co., 217 F. 2d 727 (1954), affirming *U. S. v. Denton Plumbing and Heating Co.*, 123 F. Supp. 881 (1941)). But the Seventh Circuit construes the provisions strictly. See *Bowen v. U. S. to use of Malloy*, 239 F. 2d 572 (1956).

There is much, much more that could be said about the Miller Act. Anyone who becomes involved with a government contractor in trouble will soon learn that the industry and ingenuity of counsel for claimants in previous cases have resulted in a large body of authority on almost every conceivable aspect of the Miller Act—except, very likely, the narrow issue with which you as an advocate are currently engaged.

A few words about the Capehart Act and the problems it brings. As you all know, the Capehart Act provides for construction of housing for officers and service personnel and their families. The pertinent point for those handling surety claims to remember is that the construction is on government-owned or leased property. The government issues the plans and specifications, hiring architects and engineers for such purpose. Inspections are made by these architects. The bonds provided for by 42 U.S.C. Section 1594 are dual obligee forms. The contractor is the principal, of course; and then we have the surety and two obligees—viz, a Delaware corporation which holds the lease from the government, and the financial institution that has arranged the interim financing.

The performance bond contains what is called a partnership clause which provides that if the owner or obligee under the bond does not make the required payments to the contractor, as called for by the contract, the surety is not obligated under the bond. By its terms, it provides that the surety is not liable for payment of the note provided for in the basic loan agreement, but is liable for payments of principal and interest during any default period.

Under the payment bond, a claimant is defined as one who has a direct contract with the principal or one of his subcontractors.

The claimant sues in his own name or in the name of an obligee—not in the name of the United States as under a Miller Act claim. Suit may be brought in state or federal district court.

Notice of claim must be given to two of the following: the principal, one of the obligees, or the surety. It must be in writing, identify the person to whom the materials were furnished, or for whom the work was performed. From the language of the notice provision, it seems that it must be given as an absolute condition precedent to starting suit against the surety. It must be given within 90 days from the time the last material was furnished or work performed, or within the time provided by the lien law of the jurisdiction where the work was performed, whichever period of time is the longer.

As to the A.I.A. forms, remember no one is required to use them. The lack of statutory requirements in nearly all jurisdictions concerning private work gives to the architect, who elects not to use the A.I.A. forms, the opportunity to show what a brilliant lawyer he would have been had he adopted our profession by devising his own forms. The chief beneficiaries of these architect-devised forms, as a rule, are not the owner, contractor, laborers or materialmen, but the attorneys who obtain engagements to litigate the meaning of the contracts so prepared.

The A.I.A. standard form of performance bond guarantees to the owner that the contractor will perform the contract, promptly and faithfully, and upon breach of such obligation protects the owner against loss up to the bond penalty.

The labor and material bond form promulgated by the A.I.A. binds the surety to respond if the principal does not make payment for "all labor or material used or reasonably required for use in the performance of the contract".

The form provides that unless the claimant has a direct contract with the principal no suit or action shall be commenced without having first given written notice to any two of the principal, owner, or surety, within 90 days after the claimant last performed work or labor or furnished the last of the materials included in the claim.

This provision requiring timely notice of claim has recently been construed in *United States Plywood Corp. v. Continental Casualty Company*, decided January 12, 1960 by the Municipal Court of Appeals for the District of Columbia, 157 A. 2d 286. The plaintiff had supplied material to a subcontractor in connection with a school contract. Timely notice was not given to two of the three parties designated in the provisions of the payment bond. It was the contention of the plaintiff that compliance

with the notice requirement was not a condition precedent to suit on the bond.

Disagreeing with the plaintiff's contention, and holding for the defendant, the court said,

> "The rule that the obligation is to be construed against the surety and in favor of the beneficiaries of the bond is one of construction only. In the absence of ambiguity it should not be invoked to circumvent the plain language and intent of the contracting parties . . . . It is manifest from the instrument itself that the notice of default is a condition precedent to a right of action. There is no ambiguity in the language of the contract and accordingly the application of rules of construction to achieve a different result would be improper. Courts are not at liberty to ignore the plain language and intent of the contracting parties. To do so would require them to impose liabilities the parties have not contracted for or have specifically contracted against. As stated previously, for its protection, the surety is free to impose conditions on its liability so long as they are reasonable."

We could go on at length considering the detailed nature of performance and payment bonds, whether public or private, but these are in large measure matters of legal research and analysis which the lawyer on the job will naturally cover as he proceeds with his case. Armed with a general background of knowledge of the meaning and coverage of surety bonds, we now receive word that our principal, the contractor, is in trouble. What next?

There is one principle on which all surety people agree. When it appears you have a contractor in trouble, hurry! Get there as soon as possible. As the late Allan Wight of Dallas expressed it, "Remember you are driving an ambulance—not a hearse". People in desperate financial condition do desperate things—seldom to their own benefit and never to the benefit of the surety.

When you get the call, go at once, and do not make a return reservation to bring you home on Friday. It never ceases to astonish me how some counsel investigating surety losses, both field and home office, are able to conclude their investigations and arrive at the solution to their problems on Fridays. This is so whether they have one contract in process or six, and whether they have been on the job since Monday or Wednesday.

The desire to spend the weekend at home is most commendable, but is conducive to sloppy investigation and rash conclusions. In handling a surety default you are going to be making recommendations that will save or waste substantial sums of money. It is impossible to form good conclusions on poor evidence. Get all the facts first—your wife will still be waiting if you're away three more days, but maybe your client won't be if you cut your examination short.

Disposition of payment liability is relatively simple. All you need is a knowledge of the criteria previously mentioned, a book of drafts, and a pad of release and assignment forms. When the surety first hears of the contractor's difficulties it is usually when he has no funds and a payroll to meet tomorrow. Almost always, you will meet that first payroll. Maybe you will want to shut down the job later but, if you don't, and the workmen have left, you will have a heavily disproportionate expense in starting up again.

You will be greeted by the contractor, often knee-deep in clamoring creditors. Get rid of them first—patiently but firmly. You may need their cooperation in working out your performance problems. I suggest you explain that you will have the accounts verified and, so soon as this can be done, pay that amount for which you are liable. Often, this is not enough. You will be told of how long they have helped your contractor by not insisting on payment, and they want it at once. Well, the response to this is that if they hadn't been so lenient, the surety would probably have been called in sooner—when the contractor's plight was less desperate. They helped the contractor and hurt the surety. They extended credit to an organization that was of questionable solvency, at best, and are now refusing to give a solvent surety time to learn what it owes. If there are still some creditors undisposed of, I suggest they bring suit—which will result in our getting at least twenty days to answer, more time than we need to verify the accounts, and may help some attorney earn a fee for collecting the money we are going to be willing to pay. That is usually enough.

We pay by drafts, taking executed release and assignment of the claim to the surety. We pay after investigation and verification and, where possible, with the concurrence of the contractor as to correctness of amount.

On rare occasions your investigations will show that the outstanding claims exceed

the penal amount of your bond. There is likely to be a spate of law suits, each claimant seeking to obtain an advantage by his diligence. The answer to such a situation is an interpleader action, joining all the claimants, depositing the full amount of the bond in court and requiring the claimants to establish their respective rights to the fund. Under the Federal Interpleader Act (28 U.S.C. Sections 1335, 1397 and 2361) the court will enjoin all pending or threatened law suits, discharge the surety and let the claimants have their private fight to divide the bond amount. A recent illuminating case on this subject is *Pennsylvania Fire Insurance Co. v. American Air Lines, Inc.,* 180 F. Supp. 239 (E.D.N.Y., 1960).

The real problems are those involving performance. When you received the case you received, or should receive shortly thereafter, copy of each bond, latest financial information in possession of the surety, and copies of all applications and indemnity agreements. Upon arrival at the scene, you will obtain for your use copies of the contract documents involved, a set of plans and specifications of each, and copy of the last requisition for payment, which will give you the present status of money and performance as to each job. Before becoming a lawyer, I was trained as an accountant, and I like to check the books myself or, if time does not permit, I have an accountant do it for me. I like the man who estimated each job to check over the specifications with me. Inquiry should be made as to who is going to do each item of work. This information should be checked against the subcontracts to make sure the work was so included. What isn't in the subcontracts, the contractor or his surety will have to do. Then, (and this I believe of great importance,) check all of the subcontract accounts against the payables set up in the ledger. You may find you owe much more than a check of the books would otherwise disclose.

I like to tell the contractor in the very beginning what our obligations are as a surety, and what his obligations are to us under the terms of the indemnity agreements. It is to our joint interest to keep down any loss. We will proceed in the manner we deem most practical—one of the possible avenues being to finance his operations—if he is honest, capable and cooperative. First we need all of the facts. While they are being obtained I want the contractor, as the first sample of his cooperation, to give me a letter on each job, addressed jointly to the surety and to the owner, starting he cannot continue, requesting the surety to take over, and requesting the owner to make all further contract payments as directed by the surety. I also like to obtain a power of attorney specifically authorizing us to endorse all checks, warrants, etc., received in connection with each job and to use such monies to pay bills owed or incurred in obtaining performance.

I put each owner on notice that the contractor is in difficulty, that we are proceeding to investigate and intend to discharge our liabilities as surety as soon as our investigation is completed. In the interim, I request that they forward all contract proceeds to me, but in no event to any one else, serving a copy of the assignment contained in the application.

A personal visit is made with the architect. Find out if there are contractors who would be unacceptable to him. Do not indicate you have reached any determination as to program, but let him know you are taking action and, if a new contractor is to be brought in, you want someone acceptable to him. There is no point compounding your problems by alienating the architect.

As soon as you arrived, every subcontractor knew it. You will want early information as to their abilities, the property of the prices with them, etc. Decide if you are going to want them to continue or not. If you do, put them on written notice that all of the principal's rights in the contract have been assigned to the surety. It is almost always very costly to bring in new subcontractors. Valuable time would be lost in getting them to estimate so as to give a price. The profit is usually taken in first requisitions, so that present subcontractors will often be anxious to get out, and, absent some compelling reason, you should keep them. Use the money you owe on the payment bond to advantage here. Since the Phoenicians first invented money, promise of its payment has been the most effective method of getting business men to perform.

You are working against time and must determine at the earliest reasonable opportunity, the probable cost to complete. You can do this in a number of ways—and sometimes you are justified in pursuing all of them. I like to get the three contractors who were the next low bidders to give me a firm contract price to complete, and a bid on a cost-plus basis with an upset price. Usually,

these three will assume you asked all of them. They may attempt to collude on their bids. As a check, I try to get similar bids from reputable contractors in the vicinity, but not in the immediate area. At the same time, I have the contractor's staff give me their estimate. This will invariably be too low, but in having them attempt to substantiate its propriety, you will learn much about the job and have ammunition to use in questioning others. And, sometimes, hiring an outside consultant to check is worth while.

I'll digress for a moment and say that I feel great care should be exercised in making sure that a consultant, if engaged, is restricted to his field. There seems to be an increasing tendency for surety men to engage experts. The expert makes his study, gives his report, and then proceeds to suggest the procedure to be followed in handling performance. That's your job—not his. People are inclined to take the advice of experts—but not always to be sure they stick to their field. You have probably all seen the cartoon of the country boy leaning over a drafting board saying, "A week ago I couldn't spell Ingineer and now I are one". Well, we have the same thing in the surety field: engineers and accountants, hired for a specific job in connection with a contractor's problems, gratuitously suggesting what should be done, and the person charged with the responsibility of making the decision, taking the easy way. So are surety experts made.

Well, to get back to the problem of getting the work done. As a rule of thumb, sureties will tell you they always re-let work that is in the early stages of completion. Many invariably will finish jobs in the final stages with the staff of the principal. The jobs that are neither starting nor finishing create the problem. Any general rule, however, is worth little. Your procedure should be dictated by the practicabilities of the over-all situation.

There are companies that have a fast rule that they will not finance the contractor. There are good reasons for such a position. You do not decrease your bond penalty when you finance, the personnel of the contractor will have given you low estimates of cost to complete, and they will tend to drag out performance. None of these reasons bothers me to any extent. We finance when we feel we can save money. It's a lot of work to get sufficient facts to give you enough information to make a valid decision. But if you have other bids, have questioned the basis for all costs projected by the staff of the contractor, added a reasonable percentage to the latter for safety's sake, checked the status of work and subcontracts, and find you are much lower than the best bid, then finance.

I consider the big danger in financing the fact that it is the one way the surety man becomes popular with the contractor. You must ever remember that you are trying to achieve performance expeditiously at the lowest possible cost, not win a popularity contest held by insolvent contractors. While it is nice to be liked, the goal is to save money.

The argument that you do not reduce your bond penalty disappears in the light of the fact that you do not make the decision until you have obtained the facts. If you have decided you will save money, it is no longer of any importance to reduce the bond penalty. Now, of course, you are taking a risk and, of course, many sureties have been badly burned by doing it. But isn't that an indication that they either lacked sufficient factual data for a proper decision or, if they had the facts, exercised poor judgment?

The fear that the personnel will prolong the job can easily be taken care of by incentive bonus offers to key personnel. Get a firm commitment from the few key men you will need that they will stay to the end. The bonus is only paid for prompt completion and is payable after acceptance.

Now if you are going to finance, how should you do it? First, utilize the opportunity to obtain a pledge of all available assets you can get set off as an inducement to you to do so. By financing, you are giving the contractor a chance of staying in business. He'll usually be willing to offer inducements for you so to do.

In our company, we prefer a new bank account, preferably in a different bank than the old account, and we exercise joint control. We make an initial deposit, have all job monies paid into the account, and permit withdrawals only with countersignature. But we don't countersign in the name of the surety. We designate individuals to countersign. Our name does not appear on the check. It is pointless to arrange financing and lose any advantage you can get from the apparent fact that your contractor is continuing in business by advertising on every check drawn that he is in the hands of his surety.

The agreement entered into to finance sets forth those items for which withdrawals may be made. The balance of the account can be withdrawn by the surety alone, if any insolvency action is instituted, or if the surety, in its sole judgment, has reason to apprehend that one might be instituted. Avoid any future claim of election or waiver by inserting in any such agreement language to the effect that it is in implementation of all indemnity and other agreements previously given, which are hereby affirmed as valid and subsisting.

We finance in a different manner in the case where the contractor is not insolvent but lacks liquidity, or where his insolvency appears slight and we can effect an orderly liquidation, thus avoiding the greater loss that would ensue if we had him placed in default. Here we utilize bank credit and have him pledge or mortgage to the lending bank his fixed assets. The surety guarantees the bank loan. On maturity, if the surety pays under such guarantee, the bank assigns the collateral not yet liquidated to the surety. You will often be able to acquire assets that might otherwise have been unobtainable, or which would go to a trustee in bankruptcy should an insolvency proceeding eventuate.

In financing through bank credit, utilize all controls as if you were putting in your own money, and be convinced that you have compelling reasons for dictating this course of action.

Never finance—by use of the surety's funds or bank credit—unless your contractor is honest and capable, unless you are going to exercise close supervision and, most important, unless you firmly believe you will save money.

Now, let's assume you have the normal situation—by that I mean one where you are not going to finance but relet. First, as to amount: How were the bids for completion prepared? What percentage of overhead and profit was contemplated? Arm yourself with information as to the profits being made in the same type of construction in the area. What are normal overhead costs in this type of construction business? Such information is obtainable. If general contractors in the area are averaging 3 percent profit, and your bidders want more, you have a weapon for negotiation. It is almost an unwritten law that you always demand a bond from the new contractor. Well, if it is a regular account of ours, I don't. Save the premium. Everyone says you should always avoid two losses on the one job. But if we would write the bond for this particular low bidder to us, why send him to someone else for a bond? I waive it. If I have two losses, it is no worse than the one I already have and a new one on the new contractor on another job. One and one is still two.

Well, here we are all ready to sign the relet contract. How should we go about it? First, determine the basis for the new contract. If on a pure cost-plus-a-percentage-for-overhead with an additional percentage for profit, have a clear provision as to which costs are direct and which are overhead. The same would apply where your new contract is cost-plus-a-fixed-fee. In either case, I like a ceiling—a guaranteed maximum price. These types of contracts are to be used where circumstances would have dictated your financing the insolvent contractor had he been both honest and capable. Otherwise, and almost always the best course, is the firm contract at a fixed price.

With a firm contract you are able to establish the amount of your loss. The proposal should be put in written form, addressed to the owner and delivered to the owner with the original contractor's letter of default and your letter requesting that the proposal be accepted by the owner. Upon acceptance by the owner your performance problem is behind you. There are problems of making payments for the excess cost of completion, of avoidance of assignments of the contract proceeds given by your contractor to banks or other third persons, etc., but these are generally not difficult to solve.

A word as to salvage. The fixed assets shown on the principal's financial statement are invariably grossly overstated as to value. In discussing the possibility of financing with him, you had the opportunity to learn of other assets—if he was going to disclose anything, that was the time you could have obtained it. Salvage is important, of course, but concentrate first on keeping down the loss.

Tax problems are always giving sureties great concern. The major problem involves the impact of the tax lien on the contract balances. This subject has been a matter of intensive study by a special committee of the American Bar Association. It has been exhaustively treated and I feel sure we have all been inundated with a plethora of articles dealing with it. The problem is not so bad, I submit, as generally regarded.

Where completion is financed the surety, with careful handling, will in most cases be successful in establishing its right to subrogation, thus avoiding any question of priority between it and the government and thus excluding the government from any participation in the proceeds. Where the contract has been re-let, there is less of a problem. The lien can only attach to monies due to the debtor—our now-defaulted contractor. If he does not become entitled to any funds under the contract, there is nothing which becomes subject to the imposition of the lien. The owner has a right to re-let the uncompleted work and use the balance of the fund remaining in its hands for the work, to obtain completion of performance.

I would be doing you a disservice if I concluded without pointing out that there are many problems you may encounter in handling a surety loss that I have not mentioned. My effort has been directed to dealing with the recurring problems you can anticipate. You will meet with many others of great complexity. Full knowledge of the facts and application of mature judgment will lead you to the proper solution of them.

I will, however, add this: Suretyship is a field in which everyone is an expert—and the less experience one has had the more expert he is. The underwriter knows that had you handled the case as he would have, no loss would have resulted; those ebullient souls, the productionmen, would have handled it in one-third the time, at less expense, no loss, and gotten a few good new accounts. There are others who will make themselves heard. But only you will really know if you have done a good job.

Safeguarding Against Claims in Excess of Policy Limits*

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THERE have been many informative articles written on this general topic, but in view of some recent decisions I believe it is timely to again review the subject.

Oftentimes it is difficult to determine from the opinions just what did transpire as judicial opinions can be slanted the same as lawyers' opinions. Many times there may have been justification for the companies' or attorneys' conduct and procedure which does not appear in the published opinion, but we can only deal with the facts as reported. Hence, it is not the intention to "step on anyone's toes", but only to deal with the end result as it appears on the printed page.

Asking what constitutes negligence, bad faith, or lack of good faith is somewhat like asking what constitutes sin. From Mount Sinai, we have the basic prohibitions against sin, but these have been implemented and changed by reason of man-made laws in various jurisdictions. For instance, "Thou shalt not kill"—does this apply to first degree murder, or tenth degree manslaughter, or justifiable homicide, or even the imposition of the death penalty? Is the prohibition not to steal construed as grand or petit larceny, embezzlement, first degree or fourth degree robbery? Other questions could be posed, but it suffices to say that only the facts of each case and the judgment of a jury or court will determine. It depends upon whom they are going to believe, the prosecution or the defendant.

Therefore, in considering our subject, we must reach for and determine the facts as to just what did happen in each case. The various courts have laid down certain prohibitions which must be followed in an attempt to avoid liability for judgments in excess of policy limits. There are various shades or degrees of negligence or bad faith or lack of good faith that are followed by the various courts depending upon the facts of each case. No two cases are ever precisely the same. To conclude that, based upon a certain set of facts, the insurer was or was not guilty of negligence, bad faith or lack of good faith may largely depend upon just where you are, that is, the jurisdiction in which the case will be determined. About three-fourths of our states have considered this question and, as can be imagined, there is no uniformity in the decisions, nor can there be, but each case seems to depend upon its own set of facts.

There are certain rules laid down by the various courts that are fairly universal and give us a reasonably good guide to follow in the handling of a case so as to avoid liability for judgments in excess of policy limits.

It must be realized in this era of social enlightenment, and perhaps rightly so, that the courts will closely scrutinize the conduct of the insurer in the handling and defense of a claim. It is well to point out that liability for judgments in excess of policy limits is not covered by the standard automobile or general liability policy, but it does arise from the policy. The insurer reserves the sole control of the settlement and defense of the claim and the courts have in-

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*Paper supplied by the Casualty Insurance Committee, David R. Hardy, chairman.

ferred a duty for the insurer not to disregard the interests of the insured. The liability of the insurer arises from the breach of this implied duty, during the investigation, negotiation, preparation, or trial of the case. The insuring clause of the policy has been fully complied with by the payment of the stated limits plus costs and interest as may be applicable.

The judgments against the insurer are measured by the damages sustained by the insured, either to his pocket book or his credit, because of the breach of this duty and are levied against the insurer for the failure of its employees, agents or attorneys to do certain things or in doing certain things, to take certain steps or in not taking certain steps. Some courts found such actions upon negligence; others upon bad faith or lack of good faith. It is well to remember that hindsight is usually far more accurate than foresight and the courts can use hindsight while the company and its attorneys must use foresight.

The rules set out and gathered from the various decisions must be followed to avoid liability for excess over policy limits and these may require some changes in established claim procedures as followed in some quarters, and it is well to remember the foregoing in light of today's discovery procedures. The files may not be sacred and careless remarks or recommendations and decisions without complete attending reasons therefor can later rise to afford a basis for the courts to impose liability upon an insurer.

In many of the earlier cases and still in some of the more recent cases, it was first necessary for the insured to have paid the excess before maintaining his action against his insurer on the theory that unless he paid, he suffered no damage. This rule may have its basis on the old indemnity contracts as distinguished from contracts of insurance. Some of the later cases have permitted the maintenance of the action against the insurer for the excess over policy limits where the insured has not paid the excess on the theory of damage to his credit or future credit. This is a point to be thoughtfully considered today. The mere fact the insured or his estate may not be able to respond to the third parties in damages may not preclude a suit for the excess and (if the facts warrant) a recovery therefor.

A majority of the decisions have denied the right to bring an action for excess over the policy limits to the third parties, but today there are some departures from this view. (See Kentucky, California, Massachusetts) A more startling development has been permitting the insured, his estate or trustee in bankruptcy to assign the insured's cause of action to the third parties and to permit them to maintain the action against the insurer.

While most courts still use the negligence theory (an act or omission) or bad faith or lack of good faith theory (a state of mind), it must be considered today that there is little, if any, real difference between the two in their practical application. What may be considered negligence on one hand may also be considered as evidence of bad faith, and what may be bad faith in some jurisdictions may be considered as negligence in others. The facts giving rise to the liability for excess over the policy limits can usually be determined to be either negligence or bad faith or lack of good faith. Therefore, today no matter which term is employed by the various courts, there is little, if any, practical distinction in their meaning as applied to a given set of facts. One should not say we may have been negligent, but that is a bad faith state so we are on safe ground, and vice versa. The facts can be used as a basis to fit the term used. A more practical approach is to carefully view the facts of each case and try to determine whether the insurer has breached its implied duty and obligations to the insured in the handing of a claim made against the insured.

It may be elementary to review some of the steps that must be taken by the insurer and certain steps which must be avoided by the insurer so as to tend to prevent liability in excess of policy limits from being imposed, but it is well to review these again.

The insurer must properly investigate the claim; this includes interviewing all known witnesses and running down all leads for additional witnesses and obtaining plats, pictures and, when feasible, the opinions of expert witnesses. It must determine if the plaintiff is injured and the nature and extent of the injury, either by medical reports or examinations, undercover investigations, neighborhood checks (canvass), employer checks, school checks and the like.

The insurer must defend the claim with the most competent counsel available and in the event of double or triple insureds with conflicting interests, use separate attorneys for each.

Generally speaking, the insurer must give the ad damnum letter and keep the insured advised of further demands. Generally speaking, a demand should be obtained and offers or counteroffers be made, and this is probably true even after a verdict, if it exceeds the policy limit. As one court said, even a horse trader has to make an offer at some stage.

If the company agrees to appeal, it should do so and times for filing of appeals, interpleaders, actions over and cross petitions must be observed.

The insurer must consider the seriousness of the injuries, the special damages, the probability of a large verdict and the interests of the insured, in reaching its decision whether to settle. The company may, absent fraud, settle some of the claims in a multiple claim situation, but the insured should be notified and, if possible, his consent to such settlements be obtained beforehand, preferably in writing, keeping in mind the applicable policy limits.

The company must give due regard to its attorney's recommendations and the attorney has a duty to inform the insurer of settlement demands, especially since the insurer is probably charged with notice even if he does not. Many times it is important to have a company representative with authority present during the trial, especially when the facts or the injury are in doubt, for it is oftentimes difficult for the trial attorney engaged in the heated defense of a case to give his cool, disinterested appraisal as to the progress of the case which could have a bearing upon the question or whether to settle or proceed.

In the event some of the foregoing principles are not followed, the reasons therefor should be fully substantiated by a memo to the file.

Neither the insurer nor its attorney must ever make a blunt refusal to "pay its policy limits" nor state that "it is a company policy never to do so", nor make a statement that "no Negro is worth more than $3,500" or that "we can only lose so much" (or any statement similar thereto).

An insured should not be requested, and generally should not be permitted, to contribute to a settlement within the policy limits. However, in a case of disputed coverage or the like, it might be permissible provided a written agreement is entered into beforehand.

The company should not be arbitrary in refusing a settlement or in making an offer and should not misrepresent the limits or coverage. Such misrepresentation has no place in the field of proper negotiation.

The company should not confess judgment or admit liability without the written consent of the insured, especially in a case where there is any reasonable probability the verdict could exceed the applicable limit. It is better practice to obtain the consent of the insured in any event.

It is not always necessary that the insured place the insurer on notice to accept the demand to predicate liability. The demand probably must be unequivocal. A demand such as "I'll take the policy limits" or "if you have a 10 limit, I'll take 9" or "if you have a 20 limit, I'll take 18" probably does not provide a proper basis for an excess judgment over the policy limits.

The company's refusal to accept a demand within (or including) limits must be based upon reasonable grounds, after a complete investigation and its attorneys' considered recommendations brought up-to-date and consideration given to the interests of the insured along with its own interests.

An honest mistake in judgment is not bad faith if made with a thorough knowledge of all the facts. Negligence may be a factor in considering bad faith.

The home office or supervising office of the insurer must consider all the facts along with any changes that may occur during the pendency of the claim, such as new medical information, change in witness' testimony, recent decisions, changes in the attitudes of the courts, and its attorneys' up-to-date recommendations in deciding whether to accept the demand or start trial. (Let's not forget at this point there remains the art of skillful negotiation.)

The insurer takes the risk in denying coverage and such denials along with reservation of rights and non-waiver agreements must be timely made and taken.

Written memos of all decisions as to settlement and the general handling of the case, as distinguished from preliminary or general discussions, should be kept in the file and in the event that counsel's recommendation for investigation, negotiation or settlement are rejected by the company, or vice versa, explanatory memos should be placed in the file to reflect the basis for such rejections. Oral conversations (except possi-

bly preliminary discussions) are not sufficient, as they leave room for much doubt and failing memories and subsequent criticism which could be refuted by documentary proof in a later action.

It is well to mention the possibility of the excess carrier's right to recover from the primary carrier when the primary carrier has failed to settle within its limits. There is authority that this right exists.

Another problem presented today is when acceptance of the plaintiff's demand must occur. Many people feel that the demand could be accepted, unless withdrawn, or the policy limits offered at any time up to the submission of the case to a jury or prior to the rendition of its verdict. Sometimes this poses a problem.

The question whether to appeal without the filing of a supersedeas bond can also present problems.

Upon receipt of the demand letter from the insured, consideration should be given to a reply setting out the company's position, based upon the insured's statements, the investigation, advice of counsel, etc., also requesting any additional information which the insured may possess bearing upon the question of liability or damages.

There is one soul-searching question that a claims manager or a defense attorney preparing to make his recommendation to the company can ask himself—"Would I accept the demand if we had issued an unlimited policy to the insured?"

Efforts are being made by insureds and third parties to hold the insurer's independent attorneys, as distinguished from house counsel, equally liable with the company for liability in excess of policy limits, but so far this question does not appear to have been passed upon. The day may be approaching when a decision will be forthcoming holding the attorney liable. There exists the possibility that if an insurer is held liable, it might, depending upon the facts, have an action over against its attorney. In the event the attorneys are held liable with or to the company, it could distrub the existing relationship between companies and their attorneys. It might be more difficult to obtain a conscientious appraisal of the file from the attorney, who would in many cases, be protecting his own interests and it might also have the tendency to subconsciously drive the defense men into the plaintiff's camp.

The plaintiff's attorneys (and the N.A.C.C.A. organization) are constantly making efforts to lay the groundwork or maneuver the companies into a position where a claim could be made for damages in excess of the policy limits. The company's files must be clean and complete.

Many of these decisions, which are briefly digested and attached hereto, have been brought about by some of the improvident actions of the industry and their attorneys in the past. Many of the decisions do not do violence to your way of thinking from the facts as reported, but today there is little or no excuse for a judgment to be rendered against the company in excess of its policy limits. There is no excuse for a failure to investigate or for the making of an improper investigation of a file, or for the improper handling or negotiation of a claim. Somewhere along the line, a philosophy arose in some quarters that a company was entitled to a saving on its policy contract in any event. That concept appears to have been limited to automobile and general liability contracts as it does not appear to have arisen in the other lines of insurance, such as fire, fidelity, surety and marine. Of course, a company is entitled to and should mitigate and require strict proof of damages arising from any claim, but nothing appears in the automobile or general liability policy indicating a right to a saving on or a diminution of limits where the damages and liability do not so indicate. With the elimination of the situations involving improper investigation or a demand for saving on limits where the facts do not so warrant, the vast majority of these cases would not have arisen. There is no excuse for similar decisions in the future. However, it is well to recall that in the thousands of cases handled, there have been so few mistakes brought to the surface.

On the other hand, there appears to be no sound reason for some of the remaining cases, except a change in our social philosophy to the effect that the companies could better incur the excess loss than the individual or insured, and this philosophy could lead to a sweeping revolution in the entire method of handling third party claims. Such a change could be detrimental to the interests of the third parties and their attorneys and to our courts as now constituted, along with the public in general.

In closing, it is well to remember that an ounce of prevention is worth a pound of cure.

Appendix

I

Action Against Insurer by Insured

ALABAMA

Neuberger v. Preferred Accident Ins. Co. (1921), 18 Ala. App. 72, 89 So. 90. (For defendant) (Bad faith) Assured forced to contribute to settlement.

American Mutual Liability Ins. Co. v. Cooper (1932), 1 F. 2d 446; (1938) 289 U. S. 736, 53 Sup. Ct. 595, 77 L. Ed. 1483. (For plaintiff) (Bad faith) Refusal to accept an offer when acceptance of the offer has been recommended by insurer's adjuster or counsel. Insurer must make whatever payment and settlement honest judgment and discretion dictate. Insurer must exercise reasonable diligence in making its investigation, interviewing witnesses, and otherwise ascertaining facts and its decision must be based on the facts thus ascertained.

Dalrymple v. Alabama Farm Bureau Mut. Ins. Co. (1958) Ala., 103 So. 2d 711. (For plaintiff) (Remanded) (Bad faith and negligence) Action by insured who does not pay excess.

Alabama Farm Bureau Mut. Cas. Ins. Co. v. Dalrymple, 116 So. 2d 924. (For plaintiff) (Bad faith and negligence) Not necessary to pay the excess.

Williams v. Employers Mut. Liab. Ins. Co., 131 F. 2d 601 (5 Cir.). (For defendant) (Bad faith) If the insured's own actions or misstatements are the cause of the insurer's failure to settle, the insurer should not be held for bad faith but still a jury question.

Waters v. American Cas. Co. of Reading, 73 So. 2d 524. (General liability) (For plaintiff) (Bad faith and negligence) $5,000 limit; verdict $20,000; reduced to $15,000 (demand $5,000; offer $3,750) Defendant refused to pay because of conflict of evidence. Question of good faith a jury question.

ARIZONA

Farmers Ins. Exch. v. Henderson (1957), Ariz., 313 P. 2d 404. (For plaintiff) (Bad faith) Strength of the injured claimant's case on the question of liability and damages. Action by insured who does not pay excess. Amount of financial risk to which each party is exposed in the event of refusal to settle.

ARKANSAS

Home Ind. Co. v. Snowden (1954), 264 S.W. 2d 642. (For plaintiff) (Negligence) Insured willing to contribute to settlement; insurer refused to pay anything. Assured settled and recovered up to policy limits.

CALIFORNIA

Communale v. Traders & General Ins. Co. (1953), 116 Cal. App. 2d 198, 253 P. 2d 495. (For plaintiff) Coverage question. Refusal to defend. (1958) Cal. 2d, 328 P. 2d 198, vacating (1958), Cal. App. 2d, 321 P. 2d 768. (For plaintiff) (Bad faith) Insured assigned his rights to plaintiffs. Action by insured who does not pay excess. Amount of financial risk to which each party is exposed in the event of refusal to settle.

Brown v. Guarantee Ins. Co. (1957), Cal. App. 2d, 319 P. 2d 69. (For plaintiff) (Bad faith) Failure of insurer to inform the insured of a compromise offer. Action by insured who does not pay excess. Arbitrary position of insurer in refusing settlement.

Home Indemnity Co. of New York v. Standard Accident Ins. Co., 167 F. 2d 919 (9 Cir.). (For defendant) (Bad faith) If the insured's own actions or misstatements are the cause of the insurer's failure to settle, the insurer cannot be held for bad faith. (Not a true penalty judgment case.)

Christian v. Preferred Acc. Ins. Co. (1950), U.S.D.C.N.D. California, N.D., 89 F. Supp. 888. (For plaintiff) (Bad faith)

Davy v. Public National Insurance Company (1960), 5 Cal. Rptr. 488. (For plaintiff) (Bad faith) Insurer received an offer of $4,500 with a $5,000 limit. Verdict was $24,268. Judgment for the excess and interest was affirmed. The court found that some actions on part of defendant would be negligence, but not bad faith, but affirmed the jury's finding of bad faith. The assured was willing to make a contribution. The insurance company also demanded the

insured withdraw his request for settlement and subsequently cancelled the policy because of the insured's refusal.

Ivy v. Pacific Auto Ins. Co. (1958), Cal. App. 2d, 320 P. 2d 140. (For plaintiff) (Bad faith) Action against insurer by injured party.

COLORADO

Hawkeye-Security Ins. Co. v. Indemnity Ins. Co. of N.A. (1958), 10 Cir., 260 F. 2d 361, affirming in part and reversing in part *Indemnity Ins. Co. of N.A. v. Hawkeye-Security Ins. Co.* (1958), U.S.D.C.D. Colorado, 158 F. Supp. 817. (For defendant) (Bad faith)

CONNECTICUT

Bartlett v. Travelers' Ins. Co. (1933), 117 Conn. 147, 167 Atl. 180. (For defendant) (Bad faith and negligence) Judgment creditor could not complain of prior settlement of other cases deluding limits.

Hoyt v. Factory Mut. Liab. Ins. Co. of America (1935), 120 Conn. 156, 179 Atl. 842. (For defendant) (Bad faith and negligence) Insurer not liable for using honest judgment.

DELAWARE

Stilwell v. Parsons (1958), Del., 145 A. 2d 397. (For defendant) (Bad faith) Action against insurer by injured party.

Chittick v. State Farm Mut. Auto Ins. Co. (1958), U.S.D.C.D. Delaware, 170 F. Supp. 276. (For defendant) (Bad faith) Action against insurer by injured party.

FLORIDA

Automobile Mut. Ind. Co. v. Shaw (1938), 134 Fla. 815, 185. So. 852. (For defendant) (Bad faith and negligence) Arbitrary position of insurer in refusing settlement. Action against insurer by injured party.

Tully v. Travelers' Ins. Co. (1954), U.S.-D.C.N.D. Florida, T.D., 118 F. Supp. 568. (For plaintiff) (Bad faith and negligence) Arbitrary position of insurer in refusing settlement.

Dotschay v. National Mut. Ins. Co. (1957), Florida, 5 Cir., 246 F. 2d 221. (For defendant) (Bad faith) Action by insured who does not pay excess.

American Fid. & Cas. Co. v. Greyhound Corp. (1956), 5 Cir., 232 F. 2d 89 (1958), 5 Cir., 258 F. 2d 709. (For plaintiff) (Bad faith) Failure of insured to properly investigate circumstances so as to ascertain evidence of material facts. (See *Greyhound Corporation v. Excess Ins. Co. of America* (1956), 5 Cir., 233 F. 2d 630.)

Springer v. Citizens' Cas. Co. of N.Y. (1957), 5 Cir., 246 F. 2d 123. (For plaintiff) (Bad faith) Failure to zealously guard interests of insured.

Canal Insurance Company v. Sturgis (1959), Fla., 114 So. 2d 469. (For defendant) (Bad faith) Action against insurer by injured party. (See 115 So. 2d 774 and 122 So. 2d 313)

GEORGIA

Georgia Cas. & Sur. Co. v. Reville (1958), Ga. App. 104 S.E. 2d 643, after (1957), 95 Ga. App. 358, 98 S.E. 2d 210. (For plaintiff) (Bad faith) Amount of financial risk to which each party is exposed in the event of refusal to settle.

Hall v. Preferred Acc. Ins. Co. of N.Y. (1953), 5 Cir., 204 F. 2d 844, 40 A.L.R. 2d 162. (For defendant) (Bad faith and negligence) Fault of insured in inducing insurer's rejection of compromise offer by misleading it as to facts. If the insured's own actions or misstatements are the cause of the insurer's failure to settle, the insurer cannot be held for bad faith.

Francis v. Newton (1947), 75 Ga. App. 341, 43 S.E. 2d 282. (For defendant) (Bad faith and negligence) Action against insurer by injured party.

ILLINOIS

Yordy v. Farmers Auto Ins. Ass'n. (1946), 65 N.E. 2d 619. (For plaintiff) Insured induced to contribute towards settlement.

Olympia Field Country Club v. Bankers Ins. Co. (1945), 325 Ill. App. 649, 60 N.E. 2d 896. (For plaintiff) (Bad faith) Insurer rejected advise of own counsel. Insurer fails to make or unduly delays an offer or counteroffer to settle.

Moore v. Columbia Casualty Company (1959), U.S.D.C.S.D. Illinois, S.D., 174 F. Supp. 566. (For defendant) (Bad faith) Comprehensive personal liability policy.

Ballard, et al., v. Citizens' Cas. Co. of N.Y., 196 F. 2d 96 (7 Cir., 1952). (For plaintiff) (Bad faith) Failure to settle under Illinois Dram Shop Law. Refusing settlement where there are serious injuries that would, if a recovery was sustained, far exceed policy limits. Failure to appeal.

INDIANA

Kingan & Co. v. Maryland Casualty Co. (1917) 65 Ind. App. 301, 115 N.E. 348. (For defendant) (Bad faith) Insured did not show fraud by insurer's failure to settle.

IOWA

Henke v. Iowa Home Mut. Cas. Co., 59 Iowa, 97 N.W. 2d 168. (For plaintiff) (Bad faith) Attempts by insurer to induce insured to contribute to settlement. Insured rejected advice of own counsel. Amount of financial risk to which each party is exposed in the event of refusal to settle.

Wellman v. Hawkeye-Security Ins. Co., Iowa, 94 N.W. 2d 761. (For defendant) (Bad faith)

Gretchell & Martin Lumber & Mfg. Co. v. Employers Liability Assur. Corp. (1902), 117 Iowa 180, 90 N.W. 616. (For defendant) (Negligence) Agreement to appeal not binding.

KANSAS

Sawder v. Lawrence, 129 Kan. 135, 281 P. 921. (Bad faith)

Anderson v. Southern Surety Co. (1920), 107 Kan. 375, 191 P. 583. (For plaintiff) (Negligence) Failure to present a defense was negligence.

KENTUCKY

Fidelity & Cas. Co. v. Stewart Dry Goods Co. (1925), 208 Ky. 429, 271 S.W. 444. (For defendant) (Bad faith) Fraud and bad faith not proven.

Georgia Cas. Co. v. Mann (1932), 242 Ky. 147, 46 S.W. 2d 777. (For defendant) (Bad faith and negligence) Error in judgment held not to be negligence.

American Sur. Co. of N.Y. v. J. F. Schneider & Son (1957), Ky., 307 S.W. 2d 192. (For defendant) (Bad faith) Error in judgment not bad faith.

Lemons v. State Auto Mutual Insurance Company (1959), U.S.D.C.E.D. Kentucky, C.D., 171 F. Supp. 92. (For plaintiff) (Bad faith) Action against insurer by injured party.

Strode v. Commercial Cas. Ins. Co. (1952), U.S.D.C.W.D. Kentucky, 102 F. Supp. Affirmed 202 F. 2d 599. (For defendant) (Negligence) Failure of insurer to inform the insured of a compromise offer.

LOUISIANA

New Orleans & C. R. Co. v. Maryland Casualty Co. (1905), 114 La. 153, 38 So. 89, 6 L.R.A. N.S. 562. (For defendant) (Bad faith and negligence) No bad faith shown.

Davis v. Maryland Casualty Co. (1931), 16 La. App. 253, 133 So. 769. (For defendant) (Bad faith) Taking of appeal by insurer held not to constitute bad faith.

MAINE

Rumford Falls Paper Co. v. Fidelity & Casualty Co. (1899), 92 Me. 574, 43 Atl. 503. (For defendant) (Bad faith and negligence) Insured must make whatever payments and settlement honest judgment and discretion dictate.

Wilson v. Aetna Cas. & Sur. Co. (1950), 145 Me. 370, 76 A. 2d 111, (For defendant) (Negligence) Faulty defense of injured party's action against insured. Strength of the injured claimant's case on the question of liability and damages.

MARYLAND

Lee v. Nationwide Mut. Ins. Co. (1960), U.S.D.C. 184 F. Supp. 634. (For defendant) (Bad faith) The court held that since the administratrix had not made a payment of or in the excess, they were not entitled to maintain their action and on count two, that the prayer for a declaratory judgment should fail since the distributable assets of the estate did not confer jurisdiction on the federal court.

MASSACHUSETTS

Murach v. Mass. Bonding & Ins. Co. (1959), Mass., 158 N.E. 2d 338. (For defendant) (Bad faith)

Damiano v. National Grange Mut. Liab. Co. (1944), 316 Mass. 636, 56 N.E. 2d 18, 153 A.L.R. 1402. (For plaintiff) (Bad faith and negligence) Action by trustee in bankruptcy.

Attleboro Mfg. Co. v. Frankfort Marine, Acc. & Plate Glass Ins. Co. (1917), 240 F. 573. (For plaintiff) (Negligence) Negligence in defending action.

Abrams v. Factory Mutual Liab. Ins. Co. (1937), 298 Mass. 141, 10 N.E. 2d 82. (For plaintiff) (Negligence) Faulty defense of injured party's action against insured.

MICHIGAN

City of Wakefield v. Globe Indemnity Co. (1929), 246 Mich. 645, 225 N.W. 643. (For

defendant) (Bad faith and negligence) Bad faith requires more than a showing of inadvertence or mistake. Insurer's home office failed to give consideration to all of the facts.

MINNESOTA

Mendota Electric Co. v. New York Indemnity Co. (1926), 169 Minn. 377, 211 N.W. 317. (For plaintiff) (Bad faith) Proof of reliance on advice of counsel held insufficient to prove good faith. Insurer offer to settle with claimant on the condition that the insured contribute to the settlement. Same is true when insured has actually contributed.

Boerger v. American General Insurance Company, 100 N.W. 2d 133. (For plaintiff) (Bad faith)

Mendota Electric Co. v. New York Indemnity Co. (1928), 175 Minn. 181, 221 N.W. 61. (For defendant) (Bad faith) Bad faith requires more than a showing of inadvertence or mistake.

Lawson & Nelson Sash & Door Co. v. Associated Indemnity Corp. (1938), 204 Minn. 50, 282 N.W. 481. (For defendant) (Bad faith and negligence) Attempts by insurer to induce insured to contribute to settlement. Insurer rejected advice of own counsel. Bad faith requires more than a showing of inadvertence or mistake.

Norwood v. Travelers' Ins. Co. (1939), 204 Minn. 595, 284 N.W. 785, 131 A.L.R. 1496. (For defendant) (Bad faith and negligence) Failure of insurer to inform the insured of a compromise offer. Action by insured who does not pay excess. The failure of the insurer to notify the insured of an offer to settle, without more, does not alone constitute bad faith.

Larson v. Anchor Cas. Co. (1957), Minn., 82 N.W. 2d 376. (For defendant) (Negligence) Faulty defense of injured party's action against insured. Strength of injured claimant's case on the question of liability and damages. Action by insured who does not pay excess.

MISSISSIPPI

Georgia Cas. Co. v. Cotton Mills Products Co. (1931), 159 Miss. 396, 132 So. 73. (For defendant) (Bad faith and negligence) Employers liability policy—failure to settle held not fraud or bad faith.

Farmers Gin Co. v. St. Paul Mercury Indemnity Co. (1939), 187 Miss. 747, 191 So. 415, (For defendant) (Bad faith and negligence) Action by insured who does not pay excess.

U.S.F.&G. Co. v. Canale (1958), 6 Cir., 257 F. 2d 138. (For plaintiff) (Bad faith) Strength of the injured claimant's case on the question of liability and damages.

Home Ind. Co. v. Williamson (1950), 5 Cir., 183 F. 2d 572. (For plaintiff) (Bad faith) Failure to advise insured of negotiations.

Fidelity & Cas. Co. of New York v. Gault (1952), 5 Cir., 196 F. 2d 329. (For defendant) (Bad faith) Failure to defend original action justified.

MISSOURI

Mears Mining Co. v. Maryland Cas. Co. (1912), 162 Mo. App. 178, 144 S.W. 883. (For plaintiff) (Bad faith) Insurer liable for policy limits and not pro rata portion of excess verdict.

St. Joseph Transfer & Storage Co. v. Employers Indemnity Co. (1930), 224 Mo. App. 221, 23 S.W. 2d 215. (For defendant) (Bad faith and negligence) Where insured agreed in writing to contribute on disputed claim, insurer not liable for excess.

Carthage Stone Co. v. Travelers' Ins. Co., 274 Mo. 537, 203 S.W. 822. (For plaintiff) (Bad faith) Insurer offered to settle with the claimant on the condition that the insured contribute to the settlement. Same is true when insured has actually contributed.

Maryland Casualty Co. v. Cook-O'Brien Const. Co. (1934), 69 F. 2d 462. (For plaintiff) (Bad faith and negligence) Insurer must make whatever payment and settlement honest judgment and discretion dictate. Insurer fails to make or unduly delays an offer or counteroffer to settle. Insurer offer to settle with the claimant on the condition that the insured contribute to the settlement. Same is true when insured has actually contributed.

Maryland Casualty Co. v. Elmira Coal Co. (1934), 69 F. 2d 616. (For plaintiff) (Bad faith and negligence) Action of insurer must not be arbitrary or capricious; reckless or contumacious. Action of insurer must not be fraudulent or dishonest. Insurer must make whatever payment and settlement honest judgment and discretion dictate. Placed a value on a claim before adequate investigation had been made.

McCombs v. Fidelity & Cas. Co. of N.Y. (1936), 231 Mo. App. 1206, 89 S.W. 2d 114. (For plaintiff) (Bad faith and negligence) Attempts by insurer to induce insured to contribute to settlement. Arbitrary position

of insurer in refusing settlements. Enforcement of a company rule not to settle for any amount in excess of a stated proportion of the policy coverage.

Zumwalt v. Utilities Ins. Co. (1950), 228 S.W. 2d 750. (For plaintiff) (Bad faith) Insurer offer to settle with the claimant on the condition that the insured contribute to the settlement. Same is true when insured has actually contributed. Rejections of settlement was shown to be motivated in whole or in part by the fact that the risk was partially reinsured and therefore the company had nothing to lose by refusing to settle.

Wessing v. American Ind. Co. of Galveston, Texas: Douglas v. American Ind. Co. of Galveston, Texas (1955), U.S.D.C.W.D. Missouri, C.D., 127 F. Supp. 775. (For plaintiff) (Bad faith) Action by insured who does not pay excess. Amount of financial risk to which each party is exposed in the event of refusal to settle.

Frank B. Connet Lumber Co. v. New Amsterdam Cas. Co. (1956), 8 Cir., 236 F. 2d 117. (For defendant) (Bad faith) Strength of the injured claimant's case on the question of liability and damages.

Commercial Casualty Ins. Co. v. Fruin-Colnon Contr. Co., 32 F. 2d 425 (8 Cir., 1929). (For plaintiff) (Bad faith and negligence) Failure to supersede judgment, could be negligence or bad faith.

NEBRASKA

Kleinschmit v. Farmers Mut. Hail Ins. Co. (1939), 101 F. 2d 987. (For defendant) (Bad faith and negligence) Claim by insurer that insured breached policy condition not bad faith.

State Farm Mutual Auto Ins. Co. v. Bonacci, 111 F. 2d 412 (8 Cir.,) (For defendant) (Bad faith) If the insured's own actions are the cause of the insurer's failure to settle, the insurer cannot be held for bad faith.

NEW HAMPSHIRE

Dumas v. Hartford Acc. & Ind. Co. (1942), 92 N.H. 140, 26 A. 2d 361; (1947), 94 N.H. 484, 56 A. 2d 57. (For plaintiff) (Bad faith and negligence) Attempts by insurer to induce insured to contribute to settlement. Action by insured who does not pay excess. Amount of financial risk to which each party is exposed in the event of refusal to settle. Insufficient investigation plus the existence of serious injuries and large out-of-pocket expense on part of the claimant indicating probable large verdict.

Douglas v. United States Fidelity & Guaranty Co., 81 N.H. 371, 127 Atl. 708 (1924), 37 A.L.R. 1477. (For plaintiff) (Bad faith and negligence) Failure of insured to inform counsel of all facts.

Cavanaugh Bros. v. General Accident, Fire & Life Assur. Corp. (1919), 79 N.H. 186, 106 Atl. 604. (For plaintiff) (Negligence) Insurer has duty to do what average man would do in similar situation.

Maryland Casualty Co. v. Wyoming Valley Paper Co. (1936), 84 F. 2d 633. (For plaintiff) (Negligence) Failure to make reasonable investigation.

Duncan v. Lumbermen's Mut. Cas. Co. (1941), 91 N.H. 349, 23 A. 2d 325. (For defendant) (Negligence) Action against insurer by injured party. (See also *Lumbermen's Mut. Cas. Co. v. Yeroyan*, 5 A. 2d 726)

NEW JERSEY

McDonald v. Royal Indemnity Co. (1932), 109 N.J.L. 308, 162 Atl. 620. (For defendant) (Negligence) Defense of lawsuit was not in a negligent and careless manner.

Radio Taxi Service, Inc. v. Lincoln Mutual Insurance Co., 157 A. 2d 319, decided 2-20-60 (For defendant) (Negligence)

NEW YORK

Schencke Piano Co. v. Philadelphia Casualty Co. (1915), 216 N.Y. 662, 110 N.E. 1049. (For defendant) (Bad faith and negligence) Failure to settle held not fraud or bad faith.

Auerbach v. Maryland Casualty Co. (1923), 236 N.Y. 247, 140 N.E. 577, 28 A.L.R. 1294. (For defendant) (Bad faith and negligence) Insurer not obligated to settle.

Streat Coal Co. v. Frankfort General Ins. Co. (1923), 237 N.Y. 60, 142 N.E. 352. (For defendant) (Bad faith and negligence) No bad faith shown.

Best Building Co. v. Employers Liability Assur. Corp. (1928), 247 N.Y. 451, 160 N.E. 911, 71 A.L.R. 1464. (For defendant) (Bad faith and negligence) No bad faith shown.

Garcia & Diaz v. Liberty Mut. Ins. Co. (1955), 147 N.Y.S. 2d 306. (For defendant) (Bad faith) Insurer rejected advice of own counsel.

Levin v. New England Casualty Co., 101 Misc. 402, 166 N.Y.S. 1055, (1917); Aff'd. 233 N.Y. 631, 135 N.E. 948 (1922) (For defendant) (Bad faith) Mere impolitic conduct, without more, is not sufficient evi-

dence of bad faith. Insured contributed to settlement within limits.

Brassil v. Maryland Casualty Co., 210 N. Y. 235, 104 N.E. 622 (1914), (Bad faith)

McAlleenan v. Massachusetts Bonding & Ins. Co. (1921), 232 N.Y. 190, 133 N.E. 444. (For plaintiff) (Negligence) Insurer liable for failure to appeal after agreeing to do so.

Brunswick Realty Co. v. Frankfort Ins. Co. (1917), 99 Misc. 639, 166 N.Y.S. 36. (For plaintiff) (Bad faith) Failure to settle could be bad faith.

NORTH CAROLINA

Wynnewood Lumber Co. v. Travelers' Ins. Co. (1917), 173 N.C. 269, 91 S.E. 946. (For defendant) (Bad faith and negligence) Bad faith requires more than a showing of inadvertence or mistake.

State Auto Ins. Co. v. York (1939), 104 F. 2d 730. Cert. Den. 308 U.S. 591, 34 L. Ed. 495, 60 S. Ct. 120. (For defendant) (Bad faith and negligence) Action by insured who does not pay excess.

Pennsylvania Threshermen & Farmer's Mut. Cas. Ins. Co. v. Robertson (1957), U.-S.D.C.M.D., N.C., W.S.D., 157 F.Supp. 405. (For defendant) (Bad faith and negligence Arbitrary position of insurer in refusing settlement.

Alford v. Textile Ins. Co. (1958), N.C., 103 S.E. 2d 8. (For defendant) (Bad faith) Right to settle prior judgments with one suit pending.

Henry v. Nationwide Ins. Co. (1956), U.S.D.C.E.D. North Carolina, R.D., 139 F. Supp. 806. (For defendant) (Negligence and bad faith) Failure of insured to properly investigate circumstances so as to ascertain evidence of material facts. Strength of the injured claimant's case on the question of liability and damages.

OHIO

Cleveland Wire Spring Co. v. General Accident, Fire & Life Assur. Corp. (1917), 6 Ohio App. 344, 27 O.C.A. 536. (For defendant) (Bad faith) Insurer can consider its own interests.

Hart v. Republic Mut. Insurance Co., 152 O.S. 185, 87 N.E. 2d 347. (For plaintiff) (Bad faith) Amount of financial risk to which each party is exposed in the event of refusal to settle. Action of insurer must not be arbitrary or capricious; reckless or contumacious.

J. Spang Baking Co. v. Trinity Universal Ins. Co. (1946), 45 Ohio L. Abs. 577, 68 N.E. 2d 122. (For plaintiff) (Bad faith and negligence) Attempts by insurer to induce insured to contribute to settlement. Insurer offered to settle with the claimant on the condition that the insured contribute to the settlement. Same is true when insured has actually contributed.

OKLAHOMA

Hazelrigg v. American Fid. & Cas. Co., (1955), U.S.D.C.W.D. Okla., 128 F. Supp. 40; Reversed (1955) 10 Cir., 228 F. 2d 953; (1957) 10 Cir., 241 F. 2d 871. (For defendant) (Bad faith) Amount of financial risk to which each party is exposed in the event of refusal to settle.

American Fid. & Cas. Co. v. G. A. Nichols Co. (1949), 10 Cir., 173 F. 2d 830, 31 C.C.H. 656. (For plaintiff) (Bad faith and negligence) Amount of financial risk to which each party is exposed in the event of refusal to settle.

National Mutual Cas. Co. v. Britt, 200 P. 2d 407 (1948). (For plaintiff) (Bad faith and negligence) Insurer must exercise reasonable diligence in making its investigation, interviewing witnesses and otherwise ascertaining the facts and its decision must be based on the facts thus ascertianed. Refusing settlement in good faith if it knows it has no more than an equal chance of winning and if it loses, the verdict against the insured will exceed policy limits. Refusing settlement when there are serious injuries that would, if a recovery was sustained, far exceed policy limits.

Boling v. New Amsterdam Casualty Co., 173 Okla. 160, 46 P. 2d 916 (1935). (For plaintiff) (Bad faith and negligence) Insurer must make whatever payment and settlement honest judgment and discretion dictate. Refusing settlement where there are serious injuries that would, if a recovery was sustained, far exceed policy limits. Insurer offer to settle with the claimant on the condition that the insured contribute to the settlement. Same is true when insured has actually contributed.

Traders' & General Ins. Co. v. Rudco Gas & Oil Company, 129 F. 2d 621 (1942). (For plaintiff) (Bad faith) Coverage dispute; insurer brought declaratory judgment action; insured settled with permission.

Ohio Cas. Ins. Co. v. Gordon, 95 F. 2d 605 (1938). (For defendant) (Bad faith and negligence) Insured giving erroneous information to insurer cannot claim bad faith.

American Fidelity & Cas. Co. v. All American Bus Lines, 190 F. 2d 234 (1951), Cert. Den. 72 S. Ct. 79. (For plaintiff) (Bad faith) Excess carrier recovered for primary carrier's bad faith.

Buffalo v. U.S.F.&G. Co., 84 F. 2d 883 (10 Cir.). (For defendant) (Bad faith) If the insured's own actions or misstatements are the cause of the insurer's failure to settle, the insurer cannot be held for bad faith.

State Farm Mut. Auto Ins. Co. v. Skaggs (1957), 10 Cir., 251 F. 2d 356. (For defendant) (Bad faith) No defense under policy exclusion.

American Fid. & Cas. Co. v. L. C. Jones Trucking Co. (1958), Okla., 321 P. 2d 685. (For plaintiff) (Bad faith) Must consider insured's position.

St. Paul Mercury Ind. Co. v. Martin (1951), 10 Cir., 190 F. 2d 455. (For plaintiff) (Bad faith) Good faith to excess carrier.

OREGON

Brown & McCabe Stevedores v. London Guarantee & Accident Co. (1915), 232 F. 298. (For plaintiff) (Negligence) Insurer offer to settle with the claimant on the condition that the insured contribute to the settlement. Same is true when insured has actually contributed.

Radcliffe v. Franklin National Ins. Co. of N.Y. (1956), 208 Ore. 1, 298 P. 2d 1002. (For plaintiff) (Negligence) Failure of insured to properly investigate circumstances so as to ascertain evidence of material facts. Amount of financial risk to which each party is exposed in the event of refusal to settle.

PENNSYLVANIA

Schmidt Brewing Co. v. Travelers' Ins. Co. (1914), 244 Pa. 286, 90 Atl. 683, 52 L. R.A. N.S. 126. (For defendant) (Bad faith and negligence) Insurer has decision whether to settle or try claim.

Cowden v. Aetna Cas. & Surety Co. (1957), 389 Pa. 614, 134 A. 2d 223. (For defendant) (Bad faith) Decision by insurer not to settle justified by the facts. (See *Bell v. Commercial Ins. Co. of Newark, New Jersey,* U.S. Ct. App., 3 Cir., 1960, 20 Auto Cases 2d 435. (For plaintiff) (Bad faith) Facts distinguish from *Cowden v. Aetna Cas. & Sur. Co.* since a pre-trial liability was practically conceded and with special damages of $6,000, it was probable that recovery would exceed the $10,000 limit. Court held a case of bad faith was one for the jury.

RHODE ISLAND

McGarry v. Rhode Island Mut. Ins. Co. (1960), 18 C.C.H. AUTO 1512; 40 A.L.R. 2d 168. (For defendant) (Negligence)

SOUTH CAROLINA

Tiger River Pine Co. v. Maryland Casualty Co. (1931), 163 S.C. 1229, 161 S.E. 491. (For plaintiff) (Bad faith and negligence)

Tyger River Pine Co. v. Maryland Casualty Co. (1933), 170 S.C. 286, 170 S.E. 346. (For plaintiff) (Bad faith and negligence) Bad faith a question for the jury.

Blue Bird Taxi Corp. v. American Fid. & Cas. Co. (1939), 26 F. Supp. 808. (For defendant) (Bad faith and negligence) Amount of financial risk to which each party is exposed in the event of refusal to settle. Insured sought to receive consequential damages also; refused.

Cherry v. Shelby Mut. Plate Glass & Cas. Co. (1939), 191 S.C. 177, 4 S.E. 2d 123. (For defendant) (Bad faith) Attempts by insurer to induce insured to contribute to settlement.

American Cas. Co. v. Howard (1951), 35 S.C. 704; 187 F. 2d 322 (1949) 4 Cir., 173 F. 2d 924, reversing U.S.D.C.W.D., S.C., G.D., 80 F. Supp. 983. (For defendant) (Bad faith) Decision not to settle was not bad faith.

TENNESSEE

Aycock Hosiery Mills v. Maryland Casualty Co. (1928), 157 Tenn. 599, 11 S.W. 2d 889. (For plaintiff) (Bad faith and negligence) Workmen's compensation policy —defense must be in good faith.

Vanderbilt Univ. v. Hartford A&I, Tenn., (1952), 109 F. Supp. 565. (For plaintiff) (Bad faith) Insurer rejected advice of own counsel. Arbitrary position of insurer in refusing settlement.

Home Ind. Co. v. Williamson (1950), 5 Cir., 183 F. 2d 572. (For plaintiff) (Bad faith) Failure of insurer to inform the insured of a compromise offer.

Oliver Wright v. Bituminous Cas., Ct. Appeals, 10 C.C.H. Fire & Cas. 342. (For defendant) General liability case. Defendant's attorneys said no liability.

Noshey v. American Auto Ins. Co. (1934) 68 F. 2d 808. (For plaintiff) (Bad faith and negligence) Advising insured to place property beyond reach of an anticipated judgment. Action of insurer must not be fraudulent or dishonest.

Tennessee Farmers Mut. Ins. Co. v. Hammond (1956), Tenn. 290 S.W. 2d 860; (1957), Tenn. App. 306 S.W. 2d 13. (For plaintiff) (Bad faith) Amount of financial risk to which each party is exposed in the event of refusal to settle.

Tennessee Farmers Mut. Ins. Co. v. Wood, (1960), 6 Cir., 277 F. 2d 21. (For plaintiff) (Bad faith) Settlement within the limits refused under a $5,000 policy. Verdict $15,000. Excess collected from insurer. The insurer claimed that the insured failed to cooperate. Was not sustained by the jury award.

Southern Fire & Cas. Co. v. Norris (1952), 35 Tenn. App. 657, 250 S.W. 2d 785. (For plaintiff) (Bad faith and negligence) Failure of insurer to inform the insured of a compromise offer. Failure of insured to properly investigate circumstances so as to ascertain evidence of material fact. Action by insured who does not pay excess. Failure to advise the insured of possible excess liability and to disclose to him the status of settlement negotiations.

U.S.F.&G. Co. v. Canale (1958), 6 Cir., 257 F. 2d 138. (For plaintiff) (Bad faith) Failure to give timely notice of denial of liability on policy exclusion.

Roberts v. American Fire & Casualty Co., 89 F. Supp. 827. (1950). (For plaintiff) (Bad faith) Claimant and insured were Negroes. Defendant said no Negro worth more than $3,500. Arbitrary position by defendant. *American Fire & Cas. Co. v. Roberts* (1951), 6 Cir., 186 F. 2d 921. (For plaintiff) (Bad faith and negligence) Arbitrary position of insurer in refusing settlement. Insurer must exercise reasonable diligence in making its investigation, interviewing witnesses and otherwise ascertaining the facts and its decision must be based on the facts thus ascertained.

TEXAS

Stowers Furniture Co. v. American Indemnity Co. (1929), 15 S.W. 2d 544, 39 S.W. 2d 956. (For plaintiff) (Bad faith and negligence) Insurer must exercise that degree of care that a person of ordinary care and prudence would exercise under the same or similar circumstances.

Linkenhoger v. A.F.&G. Cas. Co. (1953), 260 S.W. 2d 884. (For plaintiff) (Negligence) Rejection of reasonable settlements.

Universal Auto Ins. Co. v. Culberson (1932), 54 S.W. 2d 1061. (For plaintiff) (Bad faith) Refusal to settle is negligence. (See 86 S.W. 2d 727)

Chancey v. New Amsterdam Cas. Co., 336 S.W. 2d 763. (For defendant) (Negligence) Duty to settle and negligence are inseparable insofar as obligation to insured. Due care is all that is required. A wrong decision does not necessarily impart liability. Involves a case where settlement was not made after verdict.

Jones v. Highway Insurance Underwriters, Tex., 253 S.W. 2d 1018 (1953). (For defendant) (Bad faith and negligence) Failure of insurer to inform the insured of a compromise offer. Where the offer of the claimant to settle within policy limits or his willingness to do so does not clearly appear or appears to be conditional, the insurer cannot be said to have refused to settle within policy limits.

Highway Ins. Underwriters v. Lufkin Beaumont Motor Coaches, (1948), 215 S. W. 2d 904. (For plaintiff) (Negligence) Probably the leading case on negligence theory.

Traders & Gen. Ins. Co. v. Reed Co. Oil & Gas, 129 F. 2d 621. (For plaintiff) (Negligence)

Fidelity & Cas. Co. of N.Y. v. Robb (1959), 5 Cir., 267 F. 2d 473. (For plaintiff) (Negligence) General liability policy—must consider the interest of both.

UTAH

Paul v. Kirkendall (1957), 6 Utah 2d 256, 311 P. 2d 376. (For defendant) (Bad faith and negligence) Action against insurer by injured party.

VERMONT

Johnson v. Hardware Mut. Casualty Co. (1938), 108 Vt. 269, 187 Atl. 788. (For plaintiff) (Bad faith and negligence) Amount of financial risk to which each party is exposed in the event of refusal to settle. Insurer rejected advice of own counsel.

Johnson v. Hardware Mut. Casualty Co. (1939), 109 Vt. 481, 1 A. 2d 817. (For plaintiff) (Bad faith and negligence) Bad faith requires more than a showing of inadvertence or mistake. Refusal to accept an offer when acceptance of the offer has been recommended by the insurer's adjuster or counsel. Action of insurer must not be fraudulent or dishonest. Insurer offer to settle with the claimant on the condition that the insured contribute to the settle-

ment. Same is true when insured has actually contributed.

Farm Bureau Mut. Ins. Co. v. Violano, 123 F. 2d 692 (1941), Cert. Den., 316 U.S. 672 (1942). (For defendant) (Bad faith)

WASHINGTON

Burnham v. Commercial Cas. Ins. Co. (1941), 10 Wash. 2d 624, 117 P. 2d 644. (For defendant) (Bad faith and negligence) Faulty defense of injured party's action against insured. Failure of insured to properly investigate circumstances so as to ascertain evidence of material facts.

Evans v. Continental Cas. Co. (1952), 40 Wash. 2d 614, 245 P. 2d 470. (For plaintiff) (Bad faith) Reservation of rights. Insured arranged settlement.

Sterios v. Southern Surety Co. (1922), 122 Wash. 36, 209 P. 1107. (For defendant) (Negligence) Did not consider question of failure to appeal but evidently held there was no liability for excess.

WISCONSIN

Schwartz v. Norwich Union Indemnity Co. (1933), 212 Wis. 593, 250 N.W. 446. (For plaintiff) (Bad faith and negligence) Case involving negligent defense.

Wisconsin Zinc Co. v. Fidelity & Deposit Co. (1916), 162 Wis. 39, 155 N.W. 1081, Ann. Cas. 1918C 399. (For plaintiff) (Bad faith and negligence) Action of insurer must not be arbitrary or capricious, reckless or contumacious. Action of insurer must not be fraudulent or dishonest.

Hilker v. Western Auto Ins. Co. (1931), 204 Wis. 1, 231 N.W. 257, 235 N.W. 413. (For plaintiff) (Bad faith and negligence) Failure of insured to properly investigate circumstances so as to ascertain evidence of material facts. Insurer must exercise reasonable diligence in making its investigation, interviewing witnesses, and otherwise ascertaining the facts and its decision must be based on the facts ascertained. Insurer fails to make or unduly delays an offer or counteroffer to settle. Failure to advise the insured of possible excess liability and to disclose to him the status of settlement negotiations.

Ballard v. Ocean Accident and Guarantee Co. (1936), 86 F. 2d 449. (For plaintiff) (Bad faith and negligence) Faulty defense of injured party's action against insured. Failure of insured to properly investigate circumstances so as to ascertain evidence of material facts.

Lanferman v. Maryland Casualty Co. (1936), 222 Wis. 406, 267 N.W. 300. (For plaintiff) (Bad faith and negligence) Faulty defense of injured party's action against insured. Attempts by insurer to induce insured to contribute to settlement. Amount of financial risk to which each party is exposed in the event of refusal to settle. Setting up reserve fund over policy limits. Insurer offer to settle with the claimant on the condition that the insured contribute to the settlement. Same is true when insured has actually contributed.

Berk v. Milwaukee Auto Ins. Co. (1944), 245 Wis. 597, 15 N.W. 2d 834. (For defendant) (Bad faith) Strength of the injured claimant's case on the question of liability and damages. Insurer must exercise diligence in making its investigation, interviewing witnesses, and otherwise ascertaining facts and its decision must be based on the facts thus ascertained.

Royal Transit v. Central Sur. & Ins. Corp. (1948), 7 Cir., 168 F. 2d 345, affirming U.S.D.C.E.D., Wis., 76 F. Supp. 793, Cert. Den. *Central Sur. & Ins. Corp. v. Royal Transit,* 335 U.S. 844, 93 L. Ed. 395, 69 S. Ct. 68. (For plaintiff) (Bad faith) Insurer rejected advice of own counsel. Arbitrary position of insurer in refusing settlement. Insurer must exercise reasonable diligence in making its investigation, interviewing witnesses, and otherwise ascertaining facts and its decision must be based on the facts thus ascertained. Refusing settlement where there are serious injuries that would, if a recovery were sustained, far exceed policy limits. Insurer fails to make or unduly delays an offer or counteroffer to settle. Insurer refused to settle when there is clear liability on the part of the insured. Rejections of settlement was shown to be motivated in whole or in part by the fact that the risk was partially reinsured and therefore the company had nothing to lose by refusing to settle.

Dostal v. St. Paul Mercury Ind. Co. (1958), Wis., 89 N.W. 2d 545, 555. (For plaintiff) (Bad faith) Case involving a minor insured.

Augustin v. General Accident Fire & Life Assurance Corp., (10-4-60) U.S. Ct. App., 7 Cir., 20 2d C.C.H. Auto Cases 1269. (For plaintiff) (Bad faith) Improper investigation and trial preparation; refusal to accept offer within limits.

II

Action Against Insurer By Injured Party

CALIFORNIA

Brown v. Guarantee Ins. Co. (1957), Cal. App. 2d, 319 P. 2d 69. (For plaintiff) (Bad faith) Failure of insurer to inform the insured of a compromise offer. Action by insured who does not pay excess assignment made by trustee in bankruptcy to plaintiffs. Arbitrary position of insurer in refusing settlement.

Communale v. Traders' & General Ins. Co. (1953), 116 Cal. App. 2d 198, 253 P. 2d 495; (1953) Cal. 2d, 328 P. 2d 198, vacating (1958), Cal. App. 2d 321 P. 2d 768. (For plaintiff) (Bad faith) Action by insured who does not pay excess. Amount of financial risk to which each party is exposed in the event of refusal to settle. Assured assigned cause to plaintiffs.

DELAWARE

Chittick v. State Farm Mut. Auto Ins. Co. (1958), U.S.D.C.D., Delaware, 170 F. Supp. 276. (For defendant) (Bad faith)

Stilwell v. Parsons (1958), Del., 145 A. 2d 397. (For defendant) (Bad faith)

FLORIDA

Canal Insurance Company v. Sturgis (1959), Fla., 114 So. 2d 469. (For defendant) (Bad faith) (Also see 122 So. 2d 313)

Automobile Mut. Indemnity Co. v. Shaw (1938), 134 Fla. 815, 184 So. 852. (For defendant) (Bad faith and negligence) Arbitrary position of insurer in refusing settlement. Would allow recovery by third party if could show insurer guilty of bad faith.

GEORGIA

Francis v. Newton (1947), 75 Ga. App. 341, 43 S.E. 2d 282. (For defendant) (Bad faith and negligence) Refused third party claim on grounds of no privity.

KENTUCKY

Lemons v. State Auto Mut. Ins. Co. (1959), U.S.D.C.E.D., Kentucky, C.D., 171 F. Supp. 92. (For plaintiff) (Bad faith)

MISSOURI

Douglas v. American Ind. Co. of Galveston, Texas (1955), U.S.D.C.W.D., Missouri, C.D., 127 F. Supp. 775. (For defendant) (Bad faith)

NEBRASKA

Kleinschmit v. Farmers Mut. Hail Ins. Co. (1939), 101 F. 2d 987. (For defendant) (Bad faith and negligence) Indicated third party would have action against company if the insured did, but court found insured did not have right of action.

NEW HAMPSHIRE

Duncan v. Lumbermen's Mut. Cas. Co. (1941), 91 N.H. 349, 23 A. 2d 325. (For defendant) (Negligence) Refused third party claim. No relationship created by the policy.

OKLAHOMA

American Fid. & Cas. Co. v. All American Bus Lines, 179 F. 2d 7. Excess carrier subrogated to rights of insured and could maintain action.

TEXAS

Traders & General Ins. Co. v. Hicks Rubber Co., 169 S.W. 2d 142. Disallowed recovery by co-insurer.

UTAH

Paul v. Kirkendall (1957), 6 Utah 2d 256, 311 P. 2d 376. (For defendant) (Bad faith and negligence)

VERMONT

Farm Bureau Mut. Ins. Co. v. Violano, 123 F. 2d 692. (For defendant) (Bad faith)

Lawsuits for Wrongful Refusal to Defend or to Settle

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A. *The New Wave of Litigation*

CASUALTY insurance companies, perhaps the most desirable target defendants of all, can now brace themselves for a new wave of litigation against them. Their attorneys and possibly their claims managers may also find themselves in the unfamiliar and uncomfortable position of being co-defendants.

There is nothing new about the right to sue the insurer for a wrongful refusal to settle. There is something new in the recent California decisions that expand the scope and drastically increase the danger to an insurer of such suits. The suit may be brought by the insured, or by the third-party claimant who obtained a judgment against the insured for an amount in excess of the policy limits and who obtained an assignment from the insured. Even the reinsurer may conceivably sue the insurer for not settling within the primary limits.

It is fair to state that under these circumstances near perfection is demanded of the insurer not only in the investigation and negotiation of claims but in the opinions ultimately reached respecting liability and settlement value. Because of the existing hazard, an insurance company which has written a low limits policy has, in effect, also written a contingent type of policy with no limits and for which it received no premium.

During the past three years, California has joined many other states in recognizing the liability of an insurance company to its insured or his assignee for an excess judgment based upon the theory of a wrongful refusal to settle. While recent, these California decisions are in no sense a restrained or modest reiteration of the case law in other states; rather they are both devastating in scope and free in dicta.

Since California decisions are so frequently cited in other jurisdictions (two of these cases having been the subject of A.L.R. annotations), it is important that claims men and defense attorneys throughout the country understand this type of litigation and exercise judgment and caution to prevent these lawsuits.

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As early as 1914 in the case of *Brassil v. Maryland Casualty Co.*, 210 N.Y. 235, a casualty insurance company was forced to pay a judgment in excess of its policy limits for its wrongful refusal to settle. Since that time this type of litigation has slowly developed and in recent years has been stimulated, expanded and fostered by the NACCA oriented plaintiffs' attorneys. The result may be that an insurer will be greatly restricted in its right to allow our trial courts and juries to decide any reasonably controversial personal injury case.

In my opinion the basic reasons advanced by the courts in California in support of these lawsuits are, for the most part, fallacious. First let me point out what has occurred when an insurance company denied coverage, refused to settle and refused to defend.

B. *Wrongful Refusal to Defend Imposed Liability for an Excess Judgment*

The two decisions in the 1953 and 1958 case of *Communale v. Traders & General Insurance Company* will serve as an appropriate introduction to the related problem of liability for wrongful refusal to *defend* and of liability for wrongful refusal to *settle.*

The *first* decision, an opinion by the California District Court of Appeals (116 C.A. 2d 198, 253 P. 2d 495), held the insurance carrier liable for a refusal to defend. The California Supreme Court denied a hearing or further appeal of this case and thus gave it the stamp of approval.

The *second* decision, an unanimous opinion by the California Supreme Court, held an insurance carrier liable for refusal to settle (50 C. 2d 653, 328 P. 2d 198) and affirmed the district court opinion reported in 321 P. 2d 768. This case is discussed in an annotation appearing in 68 A.L.R. 2d 883.

Mr. and Mrs. Communale, pedestrians in a crosswalk, were hit by a hired truck driven by Mr. Sloan, the insured, who had a 10-20 policy. The carrier denied coverage under the "hired automobile exclusion". Sloan employed counsel to defend him and informed the carrier during trial that both cases could be settled for $4,000.00 and demanded that the company pay that amount. The company refused. Verdicts were returned for the plaintiffs for $25,000.00 and $1,250.00 and became final on August 13, 1950. The plaintiffs then sued the insurance company and obtained judgment for $10,000.00 and $1,250.00, (the *first* case cited above) and the insurance company paid this judgment.

Mr. Communale then obtained an assignment of all of defendant Sloan's rights and the insurance company was sued a second time. This suit sought to recover the $15,000.00 excess judgment plus interest, attorney's fees and costs incurred by Sloan in defending the original negligence suit. The entire prayer was recovered and, on appeal, the judgment was unanimously approved by the California Supreme Court in the *second* case cited above.

In this *second* case, the California Supreme Court held that the reason Traders was not in control of the negligence case was because it "wrongfully refused to defend Sloan, and the breach of its express obligation to defend did not release it from its implied duty to consider Sloan's interest in the settlement". The court treated the failure to defend as both breach of contract and as negligence, and subject to all the damages flowing from the commission of a breach of either contract or tort. The court in this *second* case further stated:

> "An insurer who denies coverage does so at its own risk, and although its position may not have been entirely groundless, if the denial is found to be wrongful it is liable for the full amount which will compensate the insured for all the detriment caused by the insurer's breach of the express and implied obligations of the contract. Certainly an insurer who not only rejected a reasonable offer of settlement but also wrongfully refused to defend should be in no better position than if it had assumed the defense and then declined to settle. The insurer should not be permitted to profit by its wrong."

In California a wrongful refusal to defend is tantamount to liability for an excess verdict. The moral of this is always to defend under a reservation of rights, or seek a declaratory relief determination before the negligence suit is tried whenever there is the slightest question about coverage, and particularly where the negligence case is one that might result in a verdict in excess of the policy limits.

Important also are the several side issues the California Supreme Court resolved in this second decision. These issues are:

1. The cause of action for wrongful refusal to settle is considered both tort and contract. It is assignable regardless of which theory the insured elects to make it. A provision in the insurance policy which states that "an assignment of an interest under the policy shall be binding only if the company consents thereto" will not preclude the transfer of a cause of action for breach of contract. Moreover, the assignment does not run afoul of the general prohibition against assignment of a tort action.

2. The statute of limitations for the cause of action for wrongful refusal to settle within the policy is four years from the date that the judgment in the bodily injury action becomes *final.* The reasoning behind this finding, according to the California Supreme Court, is that the cause of action is implied as an element of the insurance contract, and is as much a part of the instrument of the insurance contract as

if it were expressly printed in the contract. Therefore, *the four year statute* dealing with written instruments is applicable and not the two year statute dealing with quasi contracts or liabilities or obligations not based on a written instrument.

3. An interesting quotation from this case is the following:

> "When there is great risk of a recovery beyond the policy limits so that the most reasonable manner of disposing of the claim is the settlement which can be made within those limits, a consideration in good faith of the insured's interests requires the insurer to settle the claim. Its unwarranted refusal to do so constitutes a breach of the implied covenant of good faith and fair dealing."

Here, we see the court speaking in terms of good faith but in reality using the simple test of negligence.

C. *Three California Cases on Wrongful Refusal to Settle*

The earliest reported case arising in California that deals with this subject is *Christian v. Preferred Accident Insurance Company* (1950) (D.C. Cal.), 89 F. Sup. 888. In this case, the United States District Court held that liability was predicated on bad faith and not on the basis of negligence. The court's opinion relied upon an unofficially reported trial court decision in the Superior Court in San Francisco, decided on December 7, 1958 and entitled *Wong and Marr v. Metropolitan Casualty & Insurance Company.*

The *Christian* case set the stage for a landmark decision, *Brown v. Guarantee Insurance Company* (1957), 155 C.A. 2d 679, 319 P. 2d 69, 66 A.L.R. 2d 1202, which is a lengthy treatise purporting to cover the entire subject. This decision was followed by *Ivy v. Pacific Automobile Insurance Company* (1958), 156 C.A. 2d 652, 320 P. 2d 140, an interesting case but of minor significance. Then on July 22, 1958 the *Communale* decision of the Supreme Court was handed down, to the consternation of the claim executives who then shouldered yet another cross. This in turn was followed by the latest and most discouraging case, *Davy v. Public National Insurance Company* (May, 1960), 181 A.C.A. (Advance California Appellate Reports) 443, 5 Cal. R. 488.

The Brown case

In the *Brown* case, *supra,* the California District Court of Appeals reversed a trial court judgment of a Los Angeles Superior Court which had sustained the defendant's demurrer to the plaintiff's complaint for wrongful refusal to settle and did so without leave to the plaintiff to amend, holding that no such cause of action existed in California. The NACCA attorneys in the Los Angeles area joined hands in appealing the case and were eminently successful. The defendants were required to answer the complaint. After an answer was filed, and exhaustive discovery pursued, the case was settled for a substantial amount over the policy limits.

The important point of this case is that the highly inflammatory allegations in the plaintiff's complaint (which named the defense attorneys as well as the company) were at least tacitly approved by the District Court of Appeal in reversing the lower court decision. The case was not appealed to the California Supreme Court and now stands as both the law and approved form for these complaints. I personally reviewed the file of the defense counsel and found nothing that evidenced bad faith or even negligence that would have warranted this excess suit.

The appellate court pointed out in approving the complaint that the cause of action stems from a provision in the insurance contract which provides that the company has the right to control settlement, compromise and defense of the litigation. Out of this "right", there arises an implied contract between the company and the insured whereby the former agrees to act in good faith toward the latter in settlement negotiations.

After a comprehensive review of the law on this subject and the treatment of it as contained in 40 A.L.R. 2d 168, the court recognized that there was a split of authority throughout the jurisdictions as to whether an insurance company is liable on the basis of negligence or bad faith. The California District Court of Appeals then held with the majority of the other states that negligence alone is not enough and that there must be a showing of "substantial culpability on the part of the insurer—bad faith rather than mere negligence". This definition, test or rule sounds valid and what the law should be, but it is rendered meaningless when one reads further into this decision and notes the broad language

that makes defending a case to verdict a very great hazard. Most damning are the judicial illustrations of bad faith, indistinguishable from negligence in its broad sense. This importance of basing liability on bad faith rather than on negligence is winked at by our courts. These cases in California and some decisions in other jurisdiction have talked of bad faith as the test but, nevertheless, have decided the case purely on poor judgment or mistaken judgment which might be negligence but hardly the act of bad faith.

The Ivy case

Another California case which dealt with the cause of action alleging bad faith on the part of an insurer was *Ivy v. Pacific Automobile Insurance Company, supra.* The facts of this case were startling. The attorney representing Ivy, a defendant in a personal injury action, at the request of Pacific Automobile Insurance Company, stipulated that a judgment be entered against Ivy in the sum of $75,000. Unfortunately, Mr. Ivy was not consulted and the stipulated judgment was entered without his knowledge or consent. Perhaps the most disagreeable fact, at least to Mr. Ivy, was the $50,000 limit to his policy. If you've guessed that the attorney was sued with the company, you are correct. The adjuster-defendant was somehow spared by the trial court. Ivy, in the meantime, went through considerable embarrassment, was unable to enter several business transactions, and had his credit seriously impaired. The motive behind these shenanigans may be obscure, but consider in addition the further stipulations that the co-defendant driver was the agent of Ivy and "Ivy Enterprises" and in the course and scope of his employment. Add to this the fact that "Ivy Enterprises" was insured with another company.

The defense to this bad faith charge was that the Pacific Automobile Insurance Company had obtained a covenant not to execute from the plaintiff, which covered Ivy. The California District Court of Appeal rejected this defense, correctly pointing out that this covenant did not operate as a satisfaction or release of the debt. The court clearly defined the duty of the attorney hired by the insurer was to the insured-client. It is too painful to report here what the court said about the attorney but it did reverse and remand the trial court's verdict in his favor. The important thing about this case is that the court reviewed the *Brown* case, approved it and adopted some of the language that clearly distinguished the test of bad faith from the test of negligence as the basis of such a suit. See now how our next case clearly sidestepped this holding.

The Davy case

The latest and most discouraging case on this subject is *Davy v. Public National Insurance Company, supra.* In this case, there was a $5,000 policy exposure, a final pretrial demand of $4,500, an offer of $3,000, and an eventual verdict of $24,268. The case involved a police officer on a motorcycle colliding with one of Mr. Davy's taxicabs, and there were basic factual issues if either or both the red light and siren were being operated. After Davy was found personally liable for $19,268 over and above his policy limit, he sued his insurance company and its general agent for this amount plus interest. The jury returned a verdict for him against the insurance company and its general agent in the amount of $22,400.12 as prayed. The California District Court of Appeals upheld this verdict. At this time it it not known if the case will be appealed to the California Supreme Court, such an appeal not being a matter of right but allowed only if the Supreme Court grants a petition for hearing.

The insurance company did everything correctly except for the commission of one tactical error: The company threatened to and subsequently did cancel Davy's policy prior to the negligence trial and did so specifically because he refused to withdraw his demand that the company settle within the policy limits. Otherwise, the company did everything it could do. It had sent Davy an "excess letter" as soon as it had employed a very competent independent defense attorney, who was lauded for his ability by all concerned. The insurance company investigation was thorough and complete and performed by independent investigators who were promptly at the scene of the accident the night it occurred and took photographs and statements. The chance of obtaining a defense verdict was felt to have exceeded 50 percent, according to the opinion of the claims manager. The company had properly refused to allow Davy to help contribute to a settlement within the policy limits. Davy had learned from talk on the street about two weeks before the trial of a settlement demand within the policy limits. Thereafter, when confronted by Davy re-

specting the demand, the defense attorney pointed out to him, and very properly so, according to the court, that there was a conflict of interest and that he should retain his own attorney. Yet, the jury very easily found for Davy, and the appellate court leaned over backwards to sustain this finding. The real danger in all these cases is that juries are prone to be most unsympathetic with insurance companies and sympathetic with the plaintiff-insured (or his judgment creditor assignee) who presents a pathetic and destitute position. Once the jury has sympathized a verdict for the plaintiff, an appellate court seldom overrules it.

In the *Davy* case, the California District Court of Appeals found that there was substantial evidence to justify the verdict upon the following grounds:

1. A refusal to pay an additional $1,500 over and above the $3,000 offered by the company when there was a demand of $4,500 and when there was the probability that the verdict would reach $20,000, as evidenced by the jury verdict, without requesting a specific opinion as to whether the offer should be accepted from the attorney delegated to try the case, although the defense attorney had given a complete opinion as to liability previously when the demand was $4,000, and had actually transmitted to the insurance company the subsequent $4,500 demand without commenting thereon. It thus appears that there should be something in the file from the defense attorney about the propriety of accepting or rejecting an outstanding demand with as much justification for the opinion as possible. Moreover, the claims manager and adjuster and defense attorney should be similarly cautious about what they put in the file and how they converse with the claimant, his attorney and even the insured. Words, like chickens, have a way of coming home to roost.

2. The adverse inferences which might be given from the opinion of the trial attorney that the outcome of the case depended "primarily upon whom the jury believes", which the court said was a "hazardous circumstance", and the evaluation of the claims department of a "better than 50-50 chance to win", which the court stated "merely places the probability of an adverse verdict at less than 50 percent". Both statements, in my opinion, were correct, appropriate and certainly typical of what is found in such files. The attorney in a commendable fashion evaluated the case by pointing out the controlling factual issues and the pro and con testimony, which apparently predominated in favor of the defense. According to this court, these are dangerous statements to have in a file. This, in my way of thinking, is a very weak ground for showing bad faith, since it is hard to visualize a case where there is a conflict about how the accident occurred wherein the attorney or claims man would not put in some type of caveat to the effect that if the jury believed the plaintiff and rejected the more reasonable evidence, the plaintiff would collect. This perhaps points up the danger of evaluating cases on the percentage basis, or on the "good", "fair" and "bad" basis, or computing the offer upon a percent of the total policy plus the expense exposure.

3. The claims manager extended his $3,000 authorization on the basis of the possibility of an adverse verdict for "a sizeable amount" and the cost of defense, which the court obliquely inferred was a circumstantial, state-of-mind ingredient supporting bad faith. No defense medical was authorized although requested by the defense attorney.

4. The attitude of the company to protect the insured on the issue of liability but not on the issue of damages. This was an inference that the appellate court drew from the obvious fact that a verdict would probably exceed the policy limits if one were returned for the plaintiff, and the fact that the company refused to incur the expense of a defense medical as requested by the defense attorney. Once again, this is a weak ground for finding bad faith. Incidentally, the court indicated that when advising the insured of a demand within policy limits, the company must furnish the insured with the results of the investigation made and must advise the insured of the results of the investigation and must tell him of the opinion upon which the rejection is based. In addition, the court indicated that the company is obligated to give timely notice to the insured of any investigation indicating liability in excess of the poilcy limits and any offers of settlement that have been made, so that the insured may take proper steps to protect his own interest.

5. The cancellation of the insured's policy when he refused to withdraw his demand for settlement within the policy limits. While sympathetically appealing, this additional ground advanced by the court for upholding the jury verdict is admittedly weak. A company could well forego cancellation, or better time the giving of the notice of cancellation, and perhaps find some other plausible basis for cancellation.

The disturbing aspect of the *Davy* case is the tongue-in-cheek attitude of the court in finding bad faith based upon imaginary factors. The opinion is filled with comments, such as:

> "The refusal to accept a proposed settlement which under all of the circumstances is reasonable constitutes a failure to exercise good faith. Stated otherwise, an unwarranted or *unreasonable* rejection of an offer of compromise constitutes bad faith." (emphasis added) and "In determining whether an offer of settlement is warranted or reasonable, although the insurer has the right to protect its own interests, it does not have the right to sacrifice the interests of the insured."

Later on the court stated that "Neither mistaken judgment nor unreasonable judgment is the equivalent of bad faith"; but, nevertheless, the court heedlessly belied the gist of that statement in its finding.

Everyone is vulnerable to Sunday morning quarterbacking. Hindsight becomes the basis for the jury in an excess suit to stick the unpopular insurance company, and this jury is not likely to consider the decision of the jury in the original negligence case as erroneous or unsound, especially when the original jury probably had more facts and more drama before it than was presented in the retrial of the negligence case several years later before the excess liability jury. Moreover, extensive reading from a dry transcript is unimpressive. How nigh-on-to-impossible it is to successfully explain to the second jury how a witness went sour or made a poor impression or a plaintiff doctor went overboard. How easy it is to find some statement in the insurance company file or defense attorney's file that can be taken out of context or twisted or slanted to give rise to what a sympathetic jury, as the sole arbiter of the facts, can determine as bad faith. And how easy it is for the appellate court to approve the decision of the trial court. In fact, in many cases it is difficult for the appellate court to do otherwise.

D. *Some Basic Reasons Advanced by the Courts*

The foregoing California decisions set out a list of factors which should be considered in determining if the insurance company has acted in good or bad faith. Many of these same factors are also mentioned in the 1955 annotation in 40 A.L.R. 2d 168 226. Some of the basic reasons advanced by the courts will be hereafter discussed:

1. *The strength of the injured claimant's case on the issues of liability and damages:* This is a general ground which simply means: how well was the case evaluated by the claims manager and the defense attorney before the trial? Obviously, if these two individuals feel that it is a case of clear liability and one where the verdict should exceed the policy limits, failure to settle within the policy would be bad faith. The real problem presents itself with the borderline case of liability and where the damages will or might exceed the policy limits. As was seen in the *Davy* case, previously discussed, an evaluation by the claims department that the defense had a "better than 50-50 chance" to win was felt by that court to be some evidence of bad faith for refusing to settle within the policy. In this regard, it should be noted that the entire file of the insurance company and the defense attorney are open for inspection, at least in so far as correspondence and memorandums written before a verdict is returned. Thus, it behooves every adjuster, claims manager and defense attorney to be somewhat guarded in their letters and memos and notes to the file.

2. *Attempts by the insurer to induce the insured to contribute to a settlement:* There has been a split of authority on this point, but the majority of cases hold that if an insurance company tries to induce its insured to contribute to the settlement, where the demand is within the policy limits, this is an indication of bad faith. It is noted that in the *Davy* case, *supra*, the insured himself actually tried to contribute $1,500 where the demand was $4,500, the offer was $3,000 and the policy limits were $5,000. The company in that case refused to allow the insured to contribute, stating that it was against the policy of the company.

3. *Failure of the insurer to properly investigate the facts so as to ascertain the evidence against the insured:* It has been held

that where the company was notified of an accident and given the names of witnesses, and thereafter refused to interview these people and investigate the case on the merits, it was liable for bad faith. When a company contracts to assume the defense, it presupposes that it will use common sense in the defense and will properly investigate the accident. This is not to say that failure to find witnesses, which subsequently are adverse to the insured, is evidence of bad faith where there has at least been an attempt to gather this information. In this area, we find the courts talking more and more about excusable neglect as opposed to bad faith.

4. *The insurer's rejection of the advice of its own attorney or agent:* This has been frequently mentioned as having some bearing on the good or bad faith of the company. This, of course, makes a selection of competent counsel very important to the companies.

5. *Failure of the insurer to inform the insured of a compromise offer and progress of the case:* This is troubled ground, and one in which the other jurisdictions are about evenly split. Personally, I do not see any merit in this purported factor as evidencing bad faith on the part of the company, *but* this has been singled out as a ground in all four California cases which have passed on this question. Therefore, good practice would seem to dictate that whenever an excess judgment is anticipated, the company should make some provision for notifying the insured of the settlement negotiations prior to trial. In the *Davy* case, discussed *supra,* the insured indirectly learned two weeks prior to trial of the $4,500 demand. He was not informed of this by the company or the defense attorney, but the demand and counter offer were fully disclosed when Davy confronted the defense attorney with them. He thereafter complained that he was not given immediate or timely notice of the settlement offer, but the court held that he was fully informed in sufficient time to protect his interest.

Based upon this case, I recommend that a somewhat uniform type of letter be hand drafted which could be sent to the insured about one month prior to the trial date, explaining to him the settlement negotiations and outlining, in *general* terms, why the company does not feel it is a reasonable compromise, if that be the case. Consistent with honesty, the tenor of the letter should invite the approval of the insured, although not specifically ask for approval. In the average case the letter should include a statement that a thorough investigation has disclosed that this is a case of very questionable liability and that the demand is exhorbitant in view of our medical knowledge concerning the plaintiff's injuries. One or the other of these defenses, i.e., liability or damages, could be left out, in a particular case, depending upon the facts. In some rare situations, in this or in a subsequent letter, the company might go so far as to state that the insured himself could negotiate through his personal attorney with the plaintiff's attorney to effect a covenant-not-to-execute over the policy limits against the insured. The insured should be cautioned that his personal attorney should cooperate with the defense attorney and should also contact the defense attorney for an appropriate draft of this covenant-not-to-execute. This is a very ticklish area and one which might lead to creating an unhappy relationship between the insured and the company and to forcing a demand upon the company to settle at a demand figure forthwith. In some cases the injection of a personal attorney in a case is helpful. However, in light of the language of the cases and the risk to which a company is exposed, it is felt that, in some cases, such a letter would be the prudent move on the part of the company. Such a letter should be prepared by the claims manager but he should first consult with the defense attorney before undertaking the same. All such letters should be hand-tailored and given a great deal of thought.

6. *The amount of financial risk to which the insurer and insured are exposed in the event of a refusal to settle:* This is the most dangerous and illogical ground for evidencing bad faith, with which the company is faced. The dilemma can be appreciated readily when one contemplates a wrongful death case of a breadwinner where the limits are only $10,000 and the investigation discloses that the defense has the decided edge on liability. The company, in this instance, usually refuses to settle when confronted with a demand that is anywhere between $9,000 and $10,000 since the company rightly feels that it has an excellent chance of getting out altogether and the trial will end with a defense verdict since its exposure is only $10,000. The crucial questions then raised are; first, would the company have settled for the demanded amount in

the event its policy had been $100,000, and second, if a verdict were returned for the plaintiff was the demand unreasonable. Of course, the fallacy of this proposition as bad faith is that the plaintiff would never be willing to settle for a figure of $10,000, if there were higher limits. Unfortunately, the courts do not recognize the fundamental principle that when the insured purchased his low limit policy he surrendered the right of control of the case to the insurance company. Instead the courts start off with the assumption that there is a conflict of interest between the insured and the insurer and that the company can gamble, whereas the insured cannot.

If a sophisticated judge correctly analyzed this ground of alleged bad faith, he would throw it out, but the chance of this must be considered remote in view of the cases now in the books. The problem is complicated further by the court's repeated statement that, "The company and the defense attorney must consider the position of the insured to the same extent as that of the company". Obviously in terms of ability to pay their usual positions are poles apart. Every insured with low limits would much prefer the case be settled rather than risk personal loss as a result of an excess verdict. Yet, the insured assumed this danger when he elected to protect himself with low limits and if the gamble is more painful he should remember that he established the odds.

7. *The fault of the insured in inducing the insurer's rejection of the compromise offer by misleading it as to the facts:* This is an equity ground, wherein the courts have held rather uniformly that the insured will not thereafter be able to complain of the company's bad faith. In the event the insured assigns his cause of action to the plaintiff, this ground for rejecting it will be just as valid since the assignee can stand in no better shoes than the assignor. However, when the company learns in advance of trial that the insured has misrepresented the facts and the insured admits to it, the company is deprived of this defense to the allegation of bad faith.

8. *Any other facts tending to establish or negate bad faith on the part of the insurer:* This is the catch-all ground which will probably be the most important insofar as future litigation is concerned. Ingenious plaintiff attorneys can be relied upon to expand this factor. Examples are numerous and could well include the following:

a. Where a compromise is rejected after a verdict has been returned against the insured over and above the policy limits.

b. Where the insurer procures reinsurance to protect itself against an adverse judgment.

c. Where the insurance agent or insurance company representative or possibly the defense attorney advises the insured to convey real estate or other assets into the name of someone else or to place a homestead upon the property.

d. Where some loose statement is made by the company or its representatives, agents or attorneys to the effect that the best thing about the case is that the limits of liability are low.

e. Where deprecating statements are made about the religious or minority status of a party or witness or counsel as ground for an unreasonably low evaluation.

f. Where some statement appears in the file that a factor in favor of risking a trial of the case is that the insured is uncollectable.

g. Where an insurer rejects a reasonable offer to settle the case of one of several plaintiffs simply because the remaining plaintiffs will not join in a "package deal" settlement, or where the company offer is conditioned upon the compensation subrogation claim contained in a complaint in intervention and the plaintiff's bodily injury claim being divided in a predetermined fashion.

h. Where, following an offer, the insurer increases the reserve beyond the offer or up to the policy limits.

i. Where the insurer arbitrarily says that under no circumstances will it offer more than a certain amount or certain percent.

j. Where the insurer fails to have a representative available, to increase the offer during trial when new and adverse developments warrant such an increase.

k. Where the insurer tells the insured that it will pay the policy limits if necessary, and then fails to make such an offer, or where the adjuster or the attorney holds back and fails to offer the full amount authorized.

The Attorney's Conflict of Interest

The American Bar Association, several insurance companies, the American Mutual Insurance Alliance, the Association of Casualty and Surety Companies, the Interna-

tional Claim Association, the National Association of Independent Insurers and others of the insurance industry, have formulated the following statement of principles:

> "4 (b) The companies and their representatives, including attorneys will inform the policy holder of the progress of any suit against the policy holder and its probable results. If any diversity of interest shall appear between the policy holder and the company, the policy holder shall be fully advised of the situation and invited to retain his own counsel. Without limiting the general application of the foregoing, it is contemplated that this will be done in any case in which it appears probable that an amount in excess of the limit of the policy is involved, or in any case in which the company is under a reservation of rights, or in any case in which the prosecution of a counterclaim appears advantageous to the policy holder."

While it may be possible for the house counsel of an insurance company to honestly comply with this statement of principles I have a very serious doubt that this relationship can withstand the scrutiny of a court in a "wrongful refusal to settle" suit.

Whenever the house counsel of an insurance company attempts the representation of an insured and the ad damnum exceeds the policy limit a conflict of interest is present from the inception of that representation. In most instances, house counsel is on the payroll of the insurance company, he receives the benefits extended to other company employees, he is officed at the company's expense and frequently in the same building, he accepts his instructions from the claims manager, usually shares the same file with the claims department and virtually operates out of the claim department.

In the event of a suit by the insured, who was thus represented, against the insurer for a wrongful refusal to settle, both the insurer and house counsel would be hard put to defeat an allegation of bad faith under the test of the *Davy* case. The argument that the employee-attorney asserted and protected the insured's rights and interests against his employer has little convincing force, and to persuade a judge to that conclusion would require a degree of eloquence that has not yet been heard. Where house counsel was the insured's attorney it is illogical to assert that the insured enjoyed any representation respecting the question of settlement and the advice to employ his own attorney hardly solves the problem. This proposal does little more than underline the fact of the existing conflict. Realistically, I believe we can expect the courts to conclude that house counsel accepted and maintained his company's position throughout the litigation though it was adverse to his insured-client. Remember, at this stage the company's gamble has failed, its estimate of the case was wrong, and the court has the benefit of hindsight.

On the other hand an attorney, maintaining his practice independent of the insurance company, is in a postion to clearly define his relationship with the insured-defendant. He may conscientiously point out to the insured that the insurance company is simply performing a contractual duty in providing a defense at its expense and that he is in fact bound only to serve the insured. Interestingly, or perhaps sadly enough, that attorney-client relationship continues to the end of the litigation, even in that rare instance when the insurer is no longer able to pay the attorney his fee. While it is true that the insurance company, to a large degree, controls the litigation it does not enjoy the same control over its independent counsel. When a conflict of interest develops, the independent attorney has no ethical choice. He must present this conflict to the insured-client and honestly advise him, despite the fact that this may be adverse to the company's interest. He may find it necessary to request additional counsel to represent a diversity among the defendants or advise on a coverage problem. In my 24 years I have never been criticized by a claims manager when it was necessary for me to elect a course advantageous only to the insured-client.

When, as I have pointed out, the gamble fails, the estimate of the case was wrong, and hindsight provides wisdom, the position of an insurer-defendant who has provided frank, unbiased advice to its insured through an attorney not bound to it, is on sound ground.

E. *Methods and Precautions in Dealing with the Problem of Excess Liability*

In *conclusion*, the company and its defense attorneys should always be on the lookout for possible liability over and above the policy limits. Because of the recent court decisions and their attendant publici-

ty, we can now anticipate more and more suits based upon a wrongful refusal to settle.

Whenever, after reviewing the original negligence case, the possibility exists of being sued for a wrongful refusal to settle, I suggest that the claims manager and the defense counsel make sure that they have safeguarded themselves against the exposures and pitfalls mentioned in this discussion, and that some heed also be given to the following suggestions, which do not by any means guarantee immunity from suit, but which will at least provide the means to avoid the more common and obvious mistakes:

1. Send out an excess letter. Such a letter should be sent by the company, not the attorney. The contract of insurance exists between the company and its insured, not between the insured and his appointed counsel.

2. Employ qualified independent counsel.

3. Never suggest to the insured that he contribute to a demand within the policy limits, but a guarded exception might be made if the insured initiates it and insists, and the arrangement is well documented. Contributions might also be permissible in a bona fide dispute coverage situation.

4. Investigate the claim comprehensively. Diligently and thoroughly *and promptly* investigate *every* lead and *all* issues and *all* phases of the case. When the defense is based primarily upon liability, in a case where damages will obviously exceed policy limits, obtain a defense medical even though the claimed injuries and specials seem to be legitimate. You are defending the insured, not just your policy limits.

5. Unless there is a most valid reason, comply with all requests for investigation and defense preparation suggested by the defense attorney, independent adjuster, expert, the insured, and even by the claimant's attorney. A refusal to allow the defense attorney to exercise the right of discovery, be it by deposition, inspection, medical examination or other legal means, will foreclose any explanation that surprise in trial caused the adverse verdict.

6. Obtain the independent attorney's opinion regarding liability. Equally important is his opinion regarding both demand and settlement value.

7. Orally, or by letter, inform the insured of the demand and the status of the settlement negotiations about one month before trial, and continue to keep him advised. Be certain the insured agrees with your opinion of settlement and the reasons for it, be it liability, injuries, specials or a combination of these items, and note in your file the insured's concurrence with this opinion or confirm it by letter.

8. When advising the insured of the demand and of your opinion, do not be pessimistic in either your correspondence or your oral discussions with him, but, at the same time, do not misrepresent the facts and the evaluation. In most cases, your generalized opinion respecting liability or settlement value will suffice when informing the insured of the demand. However, it is better practice to show him your file and explain upon what you base your opinion, and give him your interpretation and evaluation of the evidence. Bear in mind he is entitled to confer and must be consulted at every stage of the litigation.

9. Avoid loose conversation, rash promises or hasty opinions in conferring with the insured, the agent, the claimant or the attorney for claimant.

10. Be cautious and restrained in what you tell or write the agent. Refer him to the defense attorney should he become too inquisitive or demanding.

11. If the insured unequivocally and unreasonably demands settlement within the policy limits, the company and the defense attorney should advise him that there is a conflict of interest and that he should retain his own attorney for the limited purpose of protecting his interests over the limits. He should also be advised that he may effect a covenant-not-to-execute over and above the policy limits with the plaintiff through his own attorney, so long as the attorney for the company approves the documents before they are executed.

12. Neither the company nor the defense attorney should counsel the insured on how to protect his assets or property against execution.

13. Make sure that nothing goes into the files of the insurance company either to or from the defense attorney or the independent investigator that could be distorted, misinterpreted or misconstrued as bad faith; and put into the file everything that will

negate bad faith. Because of unwarranted and unjustified misconstructions so frequently made, intra-company correspondence, and correspondence between company and defense attorney and independent investigator and reinsurer, should be guarded. Avoid derogatory statements about anyone. The telephone is always available for any amplification of correspondence. Remember that your file and that of the defense attorney and independent investigator, and perhaps the agent and the reinsurer, will be available for inspection and may be read to the jury at the time of trial.

14. Avoid a peremptory, blunt or abritrary rejection of a demand. Such a refusal to discuss settlement would be strong evidence of bad faith when bathed in the light of hindsight. Make some effort to settle even if it requires your initiating the discussion.

15. Use more ingenuity in expressing opinions respecting liability and damages by indulging in more generalization. In a more postive fashion express your opinion of non-liability without so many caveats or equivocation. At the same time, don't ask your defense attorney to pin down his evaluations to a percentage or exact figure. Always bear in mind that opinions regarding the verdict and value of the case shift and change, even up to the time of jury deliberation.

16. Present all evidence tending to reduce damages (medical specials, earning loss, nature and extent of injuries, etc.) even though it involves expensive witnesses and experts. Your agreement to defend has no expense or coverage limits. It requires every effort to hold down damages. Again, the defense is of the insured and not the policy limits.

17. The claims manager should be in close touch with the case when it is in trial, because the good faith obligation continues during the trial and even after a verdict is returned. If the case goes awry during the trial, you must be in position to initiate an increase of your offer and possibly pay the plaintiff's demand then and there. After the adverse and excess verdict is in, you cannot refuse to settle within the policy limits if the opportunity presents itself without grave risk. The only possible basis for such refusal lies in a successful motion for a new trial or appeal, ordinarily a remote possibility.

18. The decision to appeal an adverse, excess judgment presents a knotty problem. If a substantial and prejudicial error has occurred and a reversal is likely and demand is made by the insured to prosecute an appeal, the company may be compelled to do so. This will require posting a bond to secure the judgment and if the plaintiff's verdict is affirmed, you have no problem—he will execute on the bond and collect the the entire judgment. Obviously, any agreement to appeal must be conditioned upon the insured's ability and willingness to secure the judgment in excess of the policy limits.

19. It is advisable to admit liability when it is certain that this issue will be resolved against you and the facts are inflammatory. Your good faith in refusing to settle for the policy limits is then limited to the sound opinion that the damages are not worth the limits. However, the important point is that the consent of the insured must first be obtained, and in writing, so that at some later time he cannot be heard to say that his defense was never presented. Where resistance to such consent is encountered, the appearance of a personal attorney for the insured may resolve the problem.

20. It is hazardous to deny coverage. Caution would indicate defending under a reservation, or preferably have the coverage dispute judically declared in advance of the trial of the negligence case. Refusal to defend is tantamount to being held liable for not only the excess judgment, costs and interest, but also for the insured's investigative costs and attorneys' fees.

21. Where the settlement values of the claims of several plaintiffs exceed the policy limits, act promptly to investigate and to solicit demands from each. To exhaust or substantially exhaust your policy limits on a part of the case, exposing your insured to the remaining claims or judgments, may amount to bad faith. Extreme caution should be used in this situation, and written approval of the insured obtained before any large settlement is made.

22. Do not ask the counsel you have retained on behalf of your insured for a separate written opinion on coverage. If he concludes that a denial is in order you have created a conflict of interest between him and his client. This does not foreclose a discussion of the subject, but the insured must be informed of his counsel's opinion

on the matter so that no doubt exists regarding whom he represents.

23. Do not be venturesome or overly optimistic or express opinions unrelated to the realities of the case. On the other hand, do not pay extra just because of the "possibility" of an excess suit. Any business and all lawsuits are fraught with a certain calculated risk and the plaintiffs haven't won them all.

General References

29 Am. Jur. 556-562; 40 A.L.R. 2d 168-226; 66 A.L.R. 2d 1217-1230; 68 A.L.R. 2d 892-895; 69 A.L.R. 690-696; The Insurance Law Journal (Sept. 1960) at page 553 and also at page 565; the National Underwriter (Sept. 23, 1960) at page 15; 26 Cal. State Bar Jour. 355; and the following articles appearing in the Insurance Counsel Journal: 1932 Year Book p. 16; 1 (Jul. 1934) 5; 8 (Jan. 1941) 18; 8 (Oct. 1941) 45; 10 (Jan. 1943) 35; 11 (Apr. 1944) 7; 16 (Jan. 1949) 51; 16 (Apr. 1949) 94; 17 (Apr. 1950) 145; 17 (July 1950) 178 and 321; 18 (Oct. 1951) 342; 19 (Jan. 1952) 12 and 44; and 19 (Apr. 1952) 142.

Ad Damnum Demands Not To Be Exploited

IN ITS 1960 annual report the Defense Research Committee of the International Association of Insurance Counsel said, in part:

> "Exploitation before juries of plaintiffs' *ad damnum* demands is being sharply challenged, is on principle improper and can, it is believed, be eradicated in most American jurisdictions by intelligently presented test cases, even where reversals of prior decisions are necessary." (27 Ins. Counsel J. 535,536)

While that report was being printed the New Jersey Supreme Court took action in the predicted direction by adopting its amended court rule No. 4:8-1, effective September 7, 1960, reading as follows:

> "A pleading which sets forth a claim for relief, whether an original claim, cross-claim or third-party claim, shall contain (a) a statement of the facts on which the claim is based showing that the pleader is entitled to relief, and (b) a demand for judgment for the relief to which he deems himself entitled. Relief in the alternative or of several different types may be demanded. *Where unliquidated money damages are claimed in any court, other than the county district court,*[1] *the pleading shall demand damages generally without specifying the amount. Upon service of a written request by another party, the party filing the pleading shall within 5 days after service thereof furnish the requesting party with a written statement of the amount of damages claimed, which statement shall not be filed except on order of the court."*[2]

That rule is even more explicit than a similar rule that became effective in Pennsylvania in 1958, which provides:

> "Any pleading demanding relief for unliquidated damages shall, without claiming any specific sum, set forth only whether the amount is in excess of, or not in excess of, $5000."[3]

When the New Jersey Supreme Court's Committee on Rules presented the proposed amended rule to that court, it filed a memorandum discussing the reasons for the proposal. Pointing out that a claimed "useful purpose" for stating an amount in the *ad damnum* was that it formed a basis for determining jurisdiction, the committee said:

> "As to this matter, the grossly exaggerated figures now in use furnish no guide of any substantial nature for any purpose. The Federal courts might well require a more reliable showing as to the amount actually involved before accepting or retaining jurisdiction."

Another claimed "useful purpose" noted by the committee was that the statement of an amount in the *ad damnum* "enables an insurance carrier to warn a policyholder that he is exposed to the possibility that his own resources may have to be used to pay plaintiff's claim." In disposing of this contention, the committee stated:

> "Again, it would seem that the value of the clause for this purpose, as it is now used, is illusory and only results in notifications by insurance companies in a great many cases where there is no possibility of personal liability on the part of the insured. Moreover, it would appear that insurance companies can adequately protect themselves and their insureds by notice predicated upon either the company's investigation of the damages actually involved in the claim or by information obtained through prompt discovery."

Summarizing its contentions, the New Jersey committee observed:

> "The astronomical sums requested in complaints filed today bear no relation whatsoever to any realistic appraisal of the case for either purpose. At best they confuse individual clients and the general public alike, and at worst they inject into the determination of the cause at the trial level a wholly extraneous factor which may thwart a fair and proper determination by a jury. See *Botta v. Brunner,* 26 N.J. 82, 103-106 (1958). Affirmatively, the demand, at least where damages are unliquidated, serves no use-

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[1]The jurisdiction of county district courts is limited to $5000.00 in New Jersey.

[2]Italicized matter added by the recent amendment.

[3]66 Pa. Advance Rep. 67, cited in 27 Ins. Counsel J., at page 540.

ful purpose whatsoever, particularly in view of the fact that all pertinent information is available to adverse parties by way of discovery. Indeed, even in cases where the damages are liquidated there is little need for a specific amount in the demand both because the amount is usually obvious and because of the aforementioned discovery."

In promulgating the rules now in effect in New Jersey and Pennsylvania the courts of those states have added emphasis to the comments made by Judge Alexander Holtzoff in Miami in August, 1959.[4] Noting that "the purpose of the law is to do substantial justice", Judge Holtzoff stated:

"The *ad damnum* is not disclosed and is not permitted to be disclosed in my court. The purpose of the *ad damnum* is only to establish jurisdiction. It has no bearing on what should be awarded to the plaintiff by the verdict. After all, you know, any lawyer or stenographer could multiply the *ad damnum* by ten by hitting a cipher on the typewriter one additional time. It doesn't mean anything. *** It is not conducive to obtaining substantial justice to disclose a fantastic *ad damnum* to the jury or to argue that pain shouid be paid for at so much an hour or so much a day. It is immaterial what the plaintiff thinks he should be awarded. It is immaterial what the defendant thinks should be awarded to the plaintiff. All that is for the jury, or the judge, if the trial is without a jury."

[4]Proceedings of the Section of Insurance, Negligence and Compensation Law, American Bar Association, 1959, pages 163, 179-181.

"Mysterious Disappearance" Defined*

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THE 19th of April is a date of some significance in Boston. It was on that day in the year 1775 that Paul Revere rode to warn the countryside that the redcoats were coming.

The date should have special significance, also, for insurance men, because on April 19, 1943 the "mysterious disappearance clause" was born. Perhaps someone should have warned us that day to watch out for men in white coats!

While "mysterious disappearance" may not have made mental cases out of any of us, it has produced many headaches. More are bound to come. Although there was considerable sentiment toward elimination of the clause within a few years after it was introduced, "mysterious disappearance" has since spread to other policies, and it is probably here to stay.

The "mysterious disappearance clause" was introduced in the Residence and Outside Theft Policy, as part of a definition of "theft," which read:

> The word "theft" includes larceny, burglary and robbery. Mysterious disappearance of any insured property shall be presumed to be due to theft.[1]

In 1956, that policy was superseded by the Broad Form Personal Theft Policy in current use today. "Theft" is now defined as "any act of stealing," and "mysterious disappearance" has been transformed from a presumption of theft to a specifically insured peril.[2]

While no attempt will be made to identify all of the policy forms to which the term has spread, it may be noted that various Homeowners Policy forms now insure against loss by mysterious disappearance[3] or may be endorsed to provide such insurance for an additional premium;[4] and many policies, especially those affording "all risks" coverage, exclude some, if not all, "mysterious disappearance" losses.[5]

Whether, in a particular policy, "mysterious disappearance" is a presumption of theft, an insured peril, or an exclusion, it is clear that an accurate determination of the insurer's liability depends largely upon a comprehension of what is meant by the term.

One court undertook to define "mysterious disappearance" as embracing any disappearance or loss under unknown, puzzling or baffling circumstances which arouse wonder, curiosity or speculation, or circumstances which are difficult to understand or explain, and which excite, and at the same time baffle, wonder or curiosity.[6]

Such a definition is too abstract for everyday case handling purposes. Also, it is unduly flexible. Many losses under circum-

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*Presented at New Orleans on September 15, 1960 at the Mutual Loss Managers Conference under the sponsorship of the Mutual Loss Research Bureau.

[1]The clause was revised in 1948 to read:

> Mysterious disappearance of any insured property, *except a precious or semiprecious stone from its setting in any watch or piece of jewelry,* shall be presumed to be due to theft.

[2]An exclusion makes the policy inapplicable "to loss by mysterious disappearance of a precious or semiprecious stone from its setting in any watch or piece of jewelry."

[3]See, e.g., Texas Homeowners Broad Form, Form HO-B, Effective August 1, 1960.

[4]See, e.g., "Extended Theft Coverage" endorsement, Form HO-103 (Ed. 9-58), Central Forms Committee.

[5]E.g., Jewelers Block Policy; Personal Articles Floater; Texas Homeowners Broad Form. See, also, footnote 2.

[6]*Davis v. St. Paul Mercury & Indemnity,* 40 S.E. 2d 609 (N.C., 1946), discussed later herein.

stances which are "unknown" or which are asserted to be "difficult to understand or explain" should not be conceded to be mysterious disappearance losses.

It is proposed here to seek what we shall call a "working definition" of the term, by reference not only to the cases decided since 1943 in which the term has been construed, but also to earlier cases construing personal theft policies, since those cases had a definite bearing on the development of the "mysterious disappearance clause". In the course of our review, we shall consider "mysterious disappearance" as a presumption of theft, as an insured peril, and as an exclusion.

Many persons thought that the mysterious disappearance clause was designed to broaden the coverage of the policy, so as to make it extend to losses which would not otherwise be covered. They reasoned that, something new having been added to the policy, something additional in the way of protection must have been intended.

The clause was not, however, intended to give more coverage. It was simply designed to reflect what had, by 1943, long been the judicial view as to what kind of evidence it takes to prove a loss within the coverage of a theft policy.

The courts had, for many years prior to 1943, accepted proof of disappearance of insured property under mysterious circumstances as adequate to support recovery under a policy in which the insurer had agreed to pay for loss by theft. Those who drafted the Residence and Outside Theft Policy, in incorporating the "mysterious disappearance" wording, were motivated, not so much by a sense of Confucian resignation as by a desire to make the policy more informative in this respect, both to insurance companies and to policyholders. Previously, the companies had varied widely in their requirements as to proof of theft. It was hoped that the new clause would bring about a greater degree of uniformity in loss adjustment practices, and thus serve to eliminate a source of policyholder dissatisfaction.[7]

Let us take a look now at some of those early cases.

[7]See "'Mysterious Disappearance' Clause—Its Background, Purpose and Effect," a memorandum by F. G. Brown, Esq., attached to Circular No. BTRR-145, issued December 13, 1946, by Mutual Insurance Rating Bureau, New York, N.Y. Also, article by Alex H. Opgenorth, Esq., "Mysterious Disappearance and Presumption of Theft Clause", Insurance Law Journal, February, 1952, p. 97.

The Early Court Decisions

Back in January, 1915, there occurred a coincidence of sorts. Within a space of three days, a New York court[8] and a Pennsylvania court[9] ruled that an insured has sufficiently established a loss within the coverage of a theft policy when he had introduced evidence of circumstances from which it could reasonably be inferred that a theft had been committed. Both courts thought that to require more — as, for example, the testimony of witnesses to the actual taking of insured property — would, from the very nature of the act of theft, make the policy next to valueless. The courts refused to impute to the insurer any such purpose. As the Pennsylvania court observed, the thief "never invites anyone, unless it be a confederate, to witness the operation."

These two cases are significant because they ran counter to the prevailing view, and they mark the origin of the concept of "mysterious disappearance".[10]

The earliest case involving a loss under a personal theft policy was decided in 1908.[11] In that case, the insured had placed a handbag containing jewelry inside a closet and had gone out for the afternoon, leaving a servant alone in the house. The handbag and jewelry disappeared. The evidence was held insufficient to prove a loss covered by a theft policy. In another early case,[12] the insured had placed a valuable locket under a pillow in her bedroom in a dwelling occupied solely by her family and two servants; before retiring a few hours later, she looked under her pillow for the locket; it

[8]*Fienglas v. New Amsterdam Casualty*, 151 N.Y.S. 371, (N.Y., 1915) (jewelry disappeared from a jewel case on top of a dresser; insured had shown several strangers through her apartment and left them for a brief period while she went to inquire whether upstairs apartment, advertised for rental, was available for inspection.)

[9]*Miller v. Massachusetts Bonding*, 93 A. 320 (Pa., 1915) (personal jewelry disappeared under circumstances suggesting that it had been stolen; facts not otherwise stated in the opinion.)

[10]An earlier case, *Fidelity & Casualty v. Dulaney*, 91 A. 574 (Md., 1914) (a butler left insured's employ under suspicious circumstances; various personal articles disappeared about same time, including gold cigarette case with diamond monogram, which was found at a railroad station in neighboring town day after butler left; evidence held sufficient to establish loss by theft) may be regarded as based on direct evidence of theft rather than what we now think of as mysterious disappearance.

[11]*Schindler v. U.S.F. & G.*, 109 N.Y.S. 723 (N.Y., 1908)

[12]*Gordon v. Aetna Indemnity*, 116 N.Y.S. 558 (N. Y., 1909)

had disappeared. This was held to constitute mere proof of a disappearance. It was held in a third case[13] that evidence of the disappearance of jewelry from a box on top of a bureau in a hotel room to which a maid had access was insufficient to prove loss by theft.

Today, each of these cases would be regarded as a classic mysterious disappearance loss. It is not hard to understand why the courts were reluctant to treat the cases as controlling precedents and sought to establish a more equitable rule.[14] After 1915, courts generally accepted evidence of the disappearance of property under mysterious circumstances as sufficient to sustain the insured's burden of proving loss by theft.

A few cases were decided in the insurer's favor, of course. One of these, decided in 1922, is worth noting. The insured had placed a diamond brooch in a buffet drawer, and left the house to visit a hospital, locking the door after her. Upon her return, she found the door unlocked but thought nothing of it as the children were then home from school. The brooch had disappeared in the meantime. It was held that the insured had failed to show a loss under circumstances supporting an inference of theft. There was one bit of evidence which probably helped the court arrive at that decision. When the loss was reported to the insurance company, the adjuster made a routine check at the precinct police station and, sure enough, a person listed on the police records as "Anna Bachman" (which was the insured's wife's name) had telephoned a report that she had lost her diamond brooch somewhere between her house and the Bronx Hospital. The insured and his wife denied that such a statement had been made, and denied that the loss had occurred that way. The result might well have been different without that evidence, however, since the case otherwise met the test of a mysterious disappearance loss.[15]

[13] *Duschenes v. National Surety*, 139 N.Y.S. 881 (N.Y., 1913)

[14] Another early New York decision in favor of the insurer, *Hart v. American Fidelity*, 126 N.Y.S. 626 (N.Y., 1911) may be defended by present day standards. (Insured cleaining pair of earrings at washstand; one earring slipped from her hand and disappeared into drainpipe; janitor called in to remove trap, reported he had done so but had not found missing earring; later, plumber called to disconnect piping, and thorough search made but earring never found; held, insured had failed to prove theft, but had established, at most, only the losing of an earring.) It is interesting to speculate how this case might have been decided ten years later, and how it would be decided today. The trend of the cases after *Fienglas* and *Miller, supra*, was such as to suggest that the insured would have prevailed. It is possible that the janitor found the earring in the trap and secreted it; that would constitute a theft. On the other hand, the earring may have been flushed through the plumbing and out into the main sewer; such a loss was not covered by the policy. Was this a mysterious disappearance? Not unless it could be established, probably by introducing evidence as to the size and shape of the earring and the contours of the plumbing, that the missing earring could hardly have gone past a specified location in the plumbing. On such proof, an inference would be warranted, from the failure to find the earring at that spot, that the janitor had found it in the trap and misappropriated it. That would be a true mysterious disappearance. See, also, *Haas v. Fidelity & Deposit Co. of Maryland*, 160 N.Y.S., 1101 (N.Y., 1916) (insured, elderly and bedridden, had worn large diamond ring and smaller ring while being bathed by male nurse; both rings disappeared; smaller ring later found in bathtub strainer but diamond ring never found, although plumbing taken apart in search for it; held, sufficient evidence of theft.)

[15] *Bachman v. New Amsterdam Casualty*, 194 N.Y. S. 89 (N.Y., 1922). Other cases decided in favor of insurer during this period: *Polstein v. General Accident*, 158 N.Y.S. 868 (N.Y., 1916) (loss of jewelry, facts not reported.) Held, circumstances shown did not eliminate possibility of "misplacement or other disposal not recalled". Such a burden is not one ordinarily placed on insured under theft policy. Case never cited as authority. *Marks v. N.J. Fidelity & P.G. Co.*, 168 N.Y.S. 627 (N.Y., 1918) (insured had moved his household from one address to another in New York City; after moving, insured unable to locate three suits, a stole, and a pair of opera glasses, all last seen at the former address but not seen packed or unpacked during the moving.) Held, nothing about the circumstances was inconsistent with the missing articles having been left at the former address and thereafter lost either through negligence or innocent act in renovating the premises which insured had vacated. This result accords with present standards. *National Surety v. Redmon*, 190 S.W. 1081 (Ky., 1917) (insured had placed diamond tie-pin in tray on dresser in his room; next day, while in saloon, he happened to glance in mirror and realized he was not wearing tie-pin; search of room unavailing; sometime afterward footprints found on shed roof just outside window of room and marks found on window.) Held, insured had undertaken to prove loss by burglary and had failed to do so. Result hard to rationalize since policy insured against loss by theft or larceny, as well as by burglary, and the evidence, if believed, was adequate to make out a case of "mysterious disappearance". It is possible that, as in *Bachman* case, *supra*, insured's testimony was not found believable by the court. A reading of the detailed recitation of facts in this case does create a suspicion that the insured was not positive that he had left the tie-pin in the tray on his dresser. Of course, if he was not sure, the case became simply one of mislaying or losing property. The importance of the element of certainty will be discussed later herein. *Rosen v. Royal Indemnity*, 156 N.E. 52 (Mass., 1927) (policy insured against loss by burglary, theft or larceny by persons other than those whose property was insured, the excluded persons being the insured and members of his household other than residence employees; early one morning, insured's wife placed handbag containing dia-

Let us now examine some of the early cases to see what criteria they suggest for our definition of "mysterious disappearance".[16]

A diamond stick pin placed in a box in a bureau drawer in insured's bedroom was missing the next day; a part-time maid had access to the room.[17]

Insured, while traveling in a Pullman car, placed her ring on a window ledge; she left the car for a moment when the train stopped; when she returned the ring was gone; only the porter and four other passengers were in the car at the time.[18]

While at a dress shop for a fitting, insured stuck her valuable brooch pin in the back of a settee and asked one of the attendants to be sure to remind her to take it with her; insured forgot the pin when she left, remembered it about one-half hour later and returned immediately to the shop, but the pin had disappeared; in the meantime, other customers and store personnel had used the fitting room.[19]

Diamond pin placed under a handkerchief box in a dresser drawer was missing a week later, although the tissue paper in which it had been wrapped was still in the drawer; workmen had been in the house, redecorating the rooms, during that period.[20]

Insured wore her diamond and emerald ring to a dinner party, and on her return placed it in a box inside a jewelry case on her dresser; the fact that she had so placed the ring was impressed upon her mind by the circumstance that, while doing so, she had occasion to study the ring and observe the way one of the gems matched the color of her costume; several persons had access to her room.[21]

Chain and locket kept in a bag behind a picture standing on a shelf in insured's bedroom; the morning after its disappearance

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[16]The holding for the insured in a number of cases decided during this period appears to rest on more or less direct evidence of theft, such as breaking and entering, ransacking, etc., or, for one reason or another, does not represent a direct application of the "mysterious disappearance" concept. However, a consideration of the facts in such cases will be helpful to an understanding of the kind and amount of evidence considered adequate by the courts under theft policies. Among such cases are: *National Surety v. Fox*, 296 S.W. 718 (Ark., 1927) (insured rented out his house fully furnished while away on an extended trip; upon his return, various personal articles were missing, doors and windows were found unlocked, and the tenants were gone); *Nixon v. Indemnity Ins. Co.*, 3 P. 2d 968 (Calif., 1931) (diamond pin missing from bedroom after dinner party; house situated on side hill; windows affording easy access had previously been entered by thieves); *Standard Accident v. Tropical State Bank*, 186 So. 805 (Fla., 1939) (bank cashier placed pile of currency on counter just inside grilled window of teller's cage; an hour later $2500 was missing from pile; many customers had been served in the meantime; it was shown to be possible for a person to reach the pile of currency from outside the cage); *Capitol Savings & Loan v. Aetna Casualty*, 264 N.W. 859 (Mich., 1936) (bearer bonds worth $2000 disappeared from cash box in an inner office to which many persons had access); *Orland v. Great Eastern Casualty*, 155 N.Y.S. 20 (N.Y., 1915) (insured returned home after several days' absence and found drawers of bureau and sideboard open, contents mussed up, and personal articles missing); *Green v. Metropolitan Casualty*, 100 Pa. Super. 274 (Pa., 1931) (valuable bracelet placed in locked bureau drawer by insured who then went out and locked outside door; upon returning, she found outside door open, bureau drawer open and bracelet gone); *National Surety v. Murphy*, 215 S.W. 461 (Tex., 1919) (insured returned to room and found contents of desk and bureau drawers dumped on bed and articles valued at $1000 missing); *Garner v. N.J. Fid. & P.G. Co.*, 200 S.W. 448 (Mo., 1918) (stranger seen entering house during insured's absence; closet found mussed up and bag containing jewelry gone.) mond ring and other jewelry in kitchen cabinet; later that day, diamond ring found missing although other jewelry still in handbag; family consisted of insured, his wife, and four children and they had in their employ a maid and chauffeur; three men had come to visit insured while he was at breakfast; later that morning, three other men, working on a sewer job nearby, came into kitchen for water.) Held, even if circumstances were found sufficient to give rise to an inference that a theft had occurred, the evidence did not exclude the possibility that such theft was committed by an excluded person, i.e., a member of the insured's household. This case, decided in 1927, is against the weight of authority at that date. The facts stated support an inference of theft by an "outsider" and the requirement that the insured negative theft by a person whose property was covered seems harsh, especially since the only such persons were the insured, his wife and his four children, at least eight other persons being more likely suspects.

[17]*Zech v. New Jersey Fid. & P.G. Co.*, 218 Ill. App. 171 (Ill., 1920). On substantially identical facts, insured held entitled to recovery in: *Kroloff v. Southern Surety*, 198 N.W. 629 (Iowa, 1924); *Stern v. Employers Liability*, 249 S.W. 739 (Mo., 1923); *Reed v. American Bonding*, 166 N.W. 196 (Neb., 1918); *Hamill v. Fidelity & Casualty*, 159 A. 205 (Pa., 1932). See also, *Caldwell v. St. Paul Mercury & Indemnity*, 49 So. 2d 570 (Miss., 1950) and *Gordon v. Eureka Casualty*, 146 A. 2d 379 (Pa., 1958), discussed later herein, involving policies including mysterious disappearance clause.

[18]*Simond v. Liverpool & London Globe*, 219 Ill. App. 300 (Ill., 1920)

[19]*Foster v. Liverpool & London Globe*, 222 Ill. App. 37 (Ill., 1921)

[20]*Emery v. Ocean Accident*, 176 N.W. 566 (Mich., 1920). On the matter of access by workmen and others, see also: *Sowden v. U. S. F. & G.*, 252 P. 208 (Kan., 1927); *McDuff v. General Accident*, 131 A. 548 (R.I., 1925); *Veneable v. Fidelity & Deposit*, 175 N.E. 305 (N.Y., 1930)

[21]*Hornbeck v. Southwestern Surety*, 195 S.W. 1054 (Mo., 1917)

was discovered, a servant employed only two weeks left suddenly without explanation; she had on occasion during insured's absence entertained her friends in the room where the chain and locket were kept.[22]

Insured's wife placed two diamond rings in a box in a drawer, locked the drawer and hid the key under some clothes; a few days later the rings were missing; insured and his family occupied rooms in a hotel and various employees of the hotel had access thereto.[23]

Insured placed her corset on the arm of a chair, put her diamonds in a chamois bag, and pinned the bag to the corset with a safety pin; several hours later, she found the safety pin open, the bag of jewelry gone, and the main entrance door to her apartment partially open.[24]

Diamond had become loose in its setting and had been removed and placed in a jar in the kitchen of insured's apartment after being held up to a light near the kitchen window for inspection; two weeks later, the diamond had disappeared; in the meantime, apartment house janitor, whose quarters command a view into the kitchen window, had spent several hours in insured's apartment as a babysitter.[25]

Insured had mislaid the key to her jewelry box and had hidden her valuable rings under a box in a dresser drawer; during the week before they were discovered missing, several people had access to the room.[26]

Insured took a diamond stud from his necktie and placed it on top of a dresser; he remembered so doing because he recalled examining the stud under the light in his room to see if the prongs were intact and whether the diamond needed cleaning; next morning, the diamond stud was missing.[27]

Insured removed a diamond stickpin valued at $1000 from his tie, removed his collar and tie, stuck the pin in the tie and left it on his dresser. He went out, closing and locking the door of his room. When he returned next morning he found the house locked as he had left it and, on entering, he found nothing out of order. While dressing to go out again, he discovered for the first time that the diamond stickpin was missing. He searched for it without success. The door to his room was closed and locked, but two windows, though closed, were not locked. There were no footprints or other evidence of anyone having entered the house. The insured was a widower, lived alone, and kept no servants. In affirming a judgment for the insured on these facts, the court observed:

> The jury, as reasonable men, knew, as well as they could know anything from human testimony, that the diamond pin which [the insured] placed on his dresser with his tie and collar did not leave there of its own volition, or without the aid of some human agency. Whether it was taken by a burglar or by some person concealed in the house or otherwise purloined makes no difference under the terms of the policy. Certain it is that the diamond was taken from the tie * * * by someone who had a knowledge of its value, to appropriate it to his own use. * * * From such facts, the jury was warranted in concluding that the diamond was taken by a being that had reason, in other words a human being, and was not carried away by a mouse or some animal not possessing the power of reasoning.[28]

The foregoing cases illustrate the kind of evidence which the courts found sufficient to support a logical inference that a disappearance of insured property was caused by theft. Those who drafted the Residence and Outside Theft Policy were familiar with these decisions, and they selected the term "mysterious disappearance" as descriptive of a loss occurring under such circumstances.[29]

For a disappearance of property to constitute a "mysterious disappearance" two conditions had to be satisfied:

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[22] *Miller v. New Amsterdam Casualty*, 110 A. 810 (N.J., 1920)

[23] *Stich v. Fidelity & Deposit*, 159 N.Y.S. 712 (N.Y., 1916)

[24] *Fine v. New Amsterdam Casualty*, 162 N.Y.S. 135 (N.Y., 1916)

[25] *Wolf v. Aetna Accident*, 170 N.Y.S. 787 (N.Y., 1918)

[26] *Bodley v. Fidelity & Casualty*, 1 Tenn. App. 720 (Tenn., 1926)

[27] *Great Eastern Casualty v. Boli*, 187 S.W. 686 (Tex., 1916)

[28] *Fidelity & Casualty v. Wathen*, 266 S.W. 4 (Ky., 1924). See also, *Perry v. Southern Surety*, 78 Pa. Super. 222 (Pa., 1922), where the policy required the insured to show *conclusively* that loss was occasioned by burglary, larceny or theft, and provided specifically that "mere disappearance" of insured property should not be deemed evidence that the loss was so occasioned. The court, in holding the insured entitled to recover on the basis of facts not reported in the opinion, said: "'Conclusively' must be construed to mean 'moral certainty', that is, that degree of proof which produces conviction in an unprejudiced mind."

[29] See footnote 7.

First: THE DISAPPEARANCE MUST BE FROM A CLEARLY IDENTIFIED LOCATION

If the insured is unable to identify with "moral certainty" the specific location from which the insured property disappeard, the disappearance is not mysterious.[30] There is nothing mysterious about losing or mislaying property; it is a common, everyday occurrence. The acceptance by the courts of proof of dissappearance of property under mysterious circumstances as proof of its loss by theft was not intended to permit recovery for the value of insured property which was simply lost or mislaid, no matter how difficult it might be for the insured to explain its whereabouts. The location from which the property disappeared should be established by direct evidence rather than by inference drawn from other facts, otherwise, any inference of theft amounts to little more than speculation.[31] The cases stress the importance of a definite recollection that the property was in a described place prior to its disappearance.

Second: THE CIRCUMSTANCES SHOULD SUGGEST THEFT AS THE LOGICAL EXPLANATION

If the circumstances support an inference that a disappearance of insured property is due to some cause other than theft, it follows that the disappearance is not a "mysterious disappearance." This is so because the term was selected for the very purpose of describing a disappearance of property under circumstances which the courts accepted as sufficient to support an inference of theft.

In case after case, reference is made to circumstances showing access by some person other than the insured to the place where the property was last seen prior to its disappearance. This is, of course, one of the circumstances which, among others, will tend to suggest theft as the logical explanation for an otherwise unexplainable disappearance of property. Where it appears from the circumstances of a particular case that no other person could have had access to the place from which the property disappeared that will tend to demonstrate that some other explanation than theft is the more logical, one such alternative explanation being the inaccuracy of the insured's recollection.

The stage is now set for a look at what

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[30]The disappearance, to qualify as mysterious, should be from a *fixed* location. The loss of a ring from a finger, a watch from a wrist, articles from trousers pockets, etc., are more logically explained on the basis of losing or mislaying than mysterious disappearance. See comment later in this paper on the case *Davis v. St. Paul Mercury & Indemnity* (insured lost $97 from trousers pocket when small boat capsized.) See, also, *Casey v. London & Lancashire,* discussed later herein. Where there is direct evidence of theft, of course, recovery under the policy does not depend on the showing of mysterious circumstances. See footnote 16, also the recent case of *Ins. Co. of North America v. Ruppert,* 156 A. 2d 796 (D. of C., 1959) (insured, while attending "Oktoberfest" in Munich, Germany, visited brewery house filled with boisterous crowd of revelers; while pushing through crowd toward a table, insured was grabbed and swung around by several men, it being consistent with the camaraderie of the occasion for strangers to dance with one another; one man, in particular, was seen to grab insured's arm, twist her about, and then suddenly disappear into the crowd; immediately thereafter, insured missed her wrist watch.) What may seem to be an exception to the requirement that the disappearance be from a fixed location is encountered in cases where property being worn or carried is lost or mislaid in an identifiable and relatively limited area, under conditions such that a failure to find it in that area gives rise to a logical inference that it was found and misappropriated by someone. This is not really an exception, however, since the area where the losing or mislaying occurred must itself be narrowly confined. In *Caldwell v. St. Paul Mercury & Indemnity,* discussed later herein, the court found the disappearance of a diamond from a ring to be a mysterious disappearance but stressed the evidence which established that the disappearance occurred sometime during a period of several hours during which the insured had not been out of a limited area in her home. However, the *Caldwell* case is borderline and *Casey v. London & Lancashire,* infra, appears to represent the sounder view.

[31]Although Wigmore rejects the idea that it is never permissible to base an inference upon an inference, he recognizes the validity of what he terms "the underlying distrust of inferences which rest upon too many intervening inferences." *Wigmore on Evidence,* 3d Edition, S.41. The proposition that an inference may not be based upon an inference is, nevertheless, stated by the courts in case after case. See cases cited in Section 41 of 1959 Pocket Supplement to *Wigmore on Evidence,* 3d Edition. The case of *Fireman's Fund v. Perry,* 5 So. 2d 862 (Fla., 1942) is open to criticism on this score. (Insured last seen wearing valuable diamond rings at dinner table, where she was taken suddenly ill and retired to her bedroom; she was out of the house on several occasions thereafter; about a week later, she again became ill, was hospitalized, and died shortly afterward. After insured's death her diamond rings were not found in the receptacle in her bedroom where she customarily placed her jewelry upon retiring. On this fact, coupled with the circumstances that two servants had access to insured's bedroom, and that insured had not been seen wearing the rings again, the court based an inference that disappearance of the rings was due to theft.)

the courts, since 1943, have actually done with the "mysterious disappearance clause." It would be nice to be able to say that they immediately recognized and applied the principles we have just suggested as underlying the introduction of the clause. That would not be entirely accurate. In fact, in the very first case involving appellate court review of the clause it appears that the court sought to reach the correct result through the wrong door. Also, the courts had considerable difficulty in deciding how to deal with the "presumption of theft" created by a mysterious disappearance, a point we shall discuss later in this paper. We shall see, however, that, on the whole, the cases reached results which are in accord with what we construe to be the true significance of "mysterious disappearance" and they offer valuable guideposts.

The "Mysterious Disappearance Clause" Cases

The first reported case involving a claim under the "mysterious disappearance clause", and for that reason the most familiar citation, is *Davis v. St. Paul Mercury & Indemnity*,[32] decided in 1946 by the Supreme Court of North Carolina.

One fine day in June 1945, Mr. Davis put $97 in his pocket and went on a fishing trip with a friend. This friend was referred to by the court as "a man of high character", presumably to eliminate any suggestion that he would stoop to picking a friend's pocket. The boat capsized and Mr. Davis was thrown in the water. After recovering his tackle, poles, and other articles of personal property, he went ashore. Upon emerging from the lake he, for the first time since leaving home, felt for his money and discovered that in some manner it had disappeared.

The *Davis* case was decided in favor of the insured but, upon appeal by the insurer, was remanded for a new trial, and was subsequently settled out of court. The case is often referred to as though it decided that Mr. Davis could not recover his $97 because a loss under the circumstances described did not constitute a loss by mysterious disappearance.

Quite to the contrary. The Supreme Court of North Carolina in fact found that Mr. Davis has established a mysterious disappearance of his $97. The court asked: How did it get out of his pocket? When did it vanish? If it was lost when he fell in the pond why did it not come to the surface where it could be seen? The court thought that these questions tended to generate speculation as to just what did happen.

The court ruled that, while the trial judge had properly submitted to the jury the issue requested by the plaintiff, whether the loss was a mysterious disappearance, he had erred in not also submitting the issue requested by the insurer, namely, whether the plaintiff had sustained a loss by theft. The court felt that this deprived the insurer of the opportunity to rebut the presumption and establish that the loss was not caused by theft.

Applying our suggested tests, it would appear that Mr. Davis' loss was not a mysterious disappearance at all. On the evidence reported, the logical inference is that, when the boat capsized, the money fell out of his pocket into the water and went to the bottom of the pond. The jury should not have been permitted to decide that there was a mysterious disappearance. Since a mysterious disappearance was not shown it follows that no presumption of theft arose to be rebutted.

The next case involving the clause was decided in 1950 by the Supreme Court of Mississippi.[33]

A diamond disappeared from a ring on Mrs. Caldwell's hand. She testified that she had the ring on her finger with the stone in it about seven o'clock one evening while sitting in the living room of her home. About nine o'clock, when she was getting ready to retire, she noticed that the stone was missing. She looked for it that evening without success. Next morning, she and her maid looked for it again, using a vacuum cleaner, and straining the refuse from that instrument. A few days later, the maid was instructed to clean the closet and the rugs with the vacuum cleaner and to continue searching for the stone. Mrs. Caldwell then went out to work, and when she returned that afternoon, the maid had left and she never came back, although she was owed $2 for that day's work.

On this evidence, the court concluded that a mysterious disappearance was shown which entitled the insured to recover under the policy. The result is not entirely out of line with our present views, since the evidence indicated that the diamond was lost in a restricted area, and an inference was

[32] 40 S.E. 2d 609 (N.C., 1946) 169 A.L.R. 224

[33] *Caldwell v. St. Paul Mercury & Indemnity*, 49 So. 2d 570

supportable that the maid had found the diamond and misappropriated it. This, of course, was the purpose of the evidence that the maid had quit with $2 still owing to her.[34]

The next case clarified a point which appears to have been widely misunderstood in the first years under the "mysterious disappearance clause".[35]

Mr. Levine visited the men's room of the Mayfair Theater in New York City one Saturday evening. In washing his hands, he removed his diamond ring and placed it on the washstand. He turned to dry his hands and then forgot about the ring and left the room. He did not realize until the following morning that the ring was missing. He immediately reported the loss to the management of the Mayfair Theater and to the local police precinct. Although a detective was assigned to the case and a thorough search and investigation followed, the ring was never recovered.

The insurer argued that this was not a mysterious disappearance but simply a case of a ring having been placed on a washstand and, as the insurer expressed it, "left mislaid". There was no mystery about such a loss, it argued, because the plaintiff definitely placed the ring on the washstand and then left it at the theater. The leaving of the ring at that time created the loss and it was accounted for by plaintiff's direct testimony on the stand. In short, contended the insurer, there was nothing mysterious about the disappearance of the ring.[36]

The court dismissed this argument as based on fallacious reasoning. Said the court:

> Defendant seems to be under the impression that there is no mystery about the loss because the plaintiff remembers definitely that he placed the ring on the washstand. Of course, there is no mystery about the placing of the ring; however, there is a mystery as to its disappearance. What happened to the ring after the plaintiff walked out and left it on the washstand is unknown and unexplainable. The fact that he remembers he left it on the washstand does not explain the disappearance. What happened to the ring after it was placed on the washstand is a mystery. The disappearance of the ring has never been explained. * * * Property is "lost or mislaid" if a person cannot remember where he placed the article and therefore cannot find it. In such a case, there is no mysterious disappearance. It might have been stolen, but the presumption of theft in the policy would not apply because those facts do not establish that the property has disappeared mysteriously. However, assume that a person remembers where he placed the article. If it is not in its place when he attempts to recover it, it has disappeared in a mysterious * * * manner.

Now let us turn to a type of loss, commonly reported, which would probably not have been litigated but for the mysterious disappearance clause. This one happened right here in New Orleans.

Mrs. Loop placed a valuable ring on her right hand, and, with her husband, drove to the business section of New Orleans, about three miles from her residence. She carried, but did not put on, a pair of gloves. They parked the car at a garage in the business district and Mrs. Loop walked a few city blocks to a store on Canal Street. She then walked to her husband's office in the Cotton Exchange Building. They then picked up their car at the garage and drove

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[34]The court emphasized the thorough search which, in the limited area involved, should have resulted in the finding of the diamond, citing the *McDuff* case (footnote 20), and, as to the probative value of the circumstances under which the maid quit, the *Emery*, *Reed* and *Kroloff* cases. (See footnotes 17 and 20). It appears that the insurer suggested but did not undertake to establish, that it was entirely possible that the diamond was still in the house, possibly in the lavatory or the kitchen sink. The court dismissed these suggestions as speculations or surmises. On the point of certainty as to the area from which the property disappeared the case is borderline and should not be extended beyond the limits of its particular facts. See discussion in footnotes 30 and 31.

[35]*Levine v. Accident & Casualty Ins. Co.*, 112 N. Y.S. 2d 397 (N.Y., 1952)

[36]There is an interesting analogy between the insurer's argument in the *Levine* case and that made by the insured in *Erskine v. Glens Falls Indemnity*, 76 D. & C. 172, (Pa., 1951). In the *Erskine* case, the insured was wearing her diamond ring while feeding a horse. The horse plucked the diamond from its setting in the ring and the diamond could not thereafter be found. The insured's policy was one issued subsequent to the 1948 revision which excepted from the mysterious disappearance clause the loss of a precious or semiprecious stone from its setting. The insured attempted unsuccessfully to get around this exception by arguing that the loss which she was claiming was one which occurred after the known extraction of the diamond from its setting. While this was a lower court decision, and there is a temptation to dismiss it as an ingenious effort by the insured but otherwise of no significance, it points up the difficulty created by putting "mysterious disappearance" in the form of an exclusion, a problem touched on later in this paper.

to the residence of friends in the upper part of the city of New Orleans. When they arrived there, Mrs. Loop, being proud of the ring, wished to show it to her friend, but discovered, for the first time, that it was not on her finger.

Claim was filed with the insurer on the ground that the ring had "mysteriously disappeared", that this created a presumption of theft, and since there was no evidence to rebut this presumption, the loss was recoverable under the policy as a loss by theft.

The court felt that the evidence did not establish that the ring was lost as a result of theft. It agreed with the conclusion of the trial judge that there was nothing mysterious about the manner in which the ring had disappeared.[37]

This is a landmark decision in which the mysterious disappearance clause was given exactly the meaning it was intended to have. The following statement by the court warrants special emphasis:

> If she had taken it from her finger in order to wash her hands and had placed it somewhere in the washroom and had forgotten to put it back on her finger and had then returned to the washroom and found it missing, it would have been possible to classify that loss as a mysterious disappearance and to accept the presumption that there had been a theft, but *where there is no fact which can be pointed to as evidencing the remotest possibility of theft, we find it impossible to classify the disappearance as mysterious* and to accept the presumption that there was a theft. (Emphasis added).

In another case "presumption" created more of a problem than "mysterious disappearance".[38]

The insured picked up a diamond ring and a wrist watch from a jeweler who had repaired them. The ring and the watch were wrapped separately in tissue paper and placed in a small envelope with the flap left open. The insured placed the envelope in his trousers pocket and that evening played handball at a health club. After the game he recovered the envelope from the club's safe deposit box, took out the ring and showed it to his brother-in-law, then rewrapped it in tissue paper, and put it back in the envelope in his pocket. After dinner at a restaurant, the insured returned home and placed the envelope on a bureau in his bedroom without opening it. Next morning, after insured had gone to work, his wife opened the envelope and found the watch, but the ring was missing.

The court approved the following interpretation placed by the trial judge on the term "mysterious disappearance":

> Now, that clause means exactly what it says: * * * if you find that there was a mysterious disappearance of this ring then there is a presumption that that mysterious disappearance occurred by reason of theft. * * * So it is for you to determine first whether there was a mysterious disappearance. If you find there was a mysterious disappearance you may then presume that that disappearance was occasioned by theft of that ring. If you find that there was no mysterious disappearance of this property then there is not sufficient evidence on which you could make a finding of theft. * * *

The jury found for the insurance company. On appeal by the company from the granting of a new trial it was ruled that the granting of the new trial was not error where the trial judge had concluded his charge to the jury with the statement that the burden was on the insured to establish that his loss resulted from theft. The court believed that such a closing statement might have confused the jury and kept it from giving proper weight to the "presumption"; yet, it appears that the jury did not believe that a mysterious disappearance had been established, without which, of course, no presumption of theft arose.

Mr. Ruby operated a farm and dairy. In the course of repairing a trailer and painting it with creosote, he got creosote on his hands and on a ring he was wearing. He left the barn where he had been working and went to the washroom in a dairy building about 60 feet away. On his way, he observed that the large diamond was in place in his ring and that it had creosote on it. In the washroom, Mr. Ruby removed the ring and placed it on the sill of a window which could not be opened. He testified that the ring was on tight and hard to remove and this required him to pull on the setting which held the large diamond. He did not recall whether he noticed the stone at that time but he was sure that in taking off the ring he would have noticed its absence if it had been gone. His daughter called to him and he left to attend a sick horse. On

[37] *Loop v. U. S. F. & G.*, 63 So. 2d 247 (La., 1953)
[38] *Sigel v. American Guarantee & Liability*, 98 A. 2d 376 (Pa., 1953)

his return, he went to the washroom to pick up his ring. He found the ring on the sill where he had left it but the large diamond was missing.[39]

The trial judge concluded that "the preponderance of the credible evidence in the case indicates to a reasonable certainty that a theft did not take place here and the evidence is contrary to the presumption of theft."

In affirming a judgment for the insurance company, the Supreme Court of Wisconsin made the following statement:

> [I]n order to recover upon his insurance policy the assured must convince the trier of the fact that the property was stolen. If it were not for the [mysterious disappearance] provision, in many cases the insured would not be able to do this because all he is able to prove directly is that the property is gone and a finding of theft would rest on speculation alone and, therefore, would have insufficient support. But when the policy contains the "mysterious disappearance" provision a finding of theft can be sustained * * * because by contract the parties have stipulated that theft is presumed from the mysterious disappearance. * * * In the present case, the absence of any suspicious circumstances pointing toward theft, other than the mere disappearance of the daimond * * * supports an inference that a theft did not occur.

In another Louisiana case[40] the Court relied on the precedent it had established in the *Loop* case four years earlier, in holding for the insurance company on the following evidence: Mrs. Deckler last recalled seeing her ring on her finger just after dinner. According to a statement she gave to the company investigator she was wearing the ring on a finger of her right hand and she had attempted to unclog the garbage disposal unit, working at it with her right hand for about a half hour, finally managing to get it to operate; a few hours after this occurrence she noticed that the ring was missing from her right hand; she then looked for the ring in the disposal unit, but she did not have it disassembled, since she felt if it had gone into the unit it would have been ground up; she thought she had lost the ring from her finger while working with the unit and that it had gone down through the garbage disposal connection to the sewer.

The insured's testimony at the trial differed in a number of important respects from the statement given to the investigator and an effort was made to discredit that statement. However, the court concluded that, after considering all the facts and circumstances, the presumption of theft could not be applied.

In *Casey v. London & Lancashire*,[41] the insured had visited a doctor for treatment for a dislocated disc. In the waiting room, he removed from his finger a large diamond ring, valued at $2000, and placed it in his trousers pocket. Thereafter, he entered the office and underwent treatment which involved his lying on a medical table in various positions. Upon leaving the doctor's office he walked about three hundred feet down the street to a newsroom; there he purchased a paper which he read for about 15 minutes and then went into the restroom at the rear of the newsroom; it was at this point that he found that the ring was no longer in his pocket. It appeared that he carried change in both of his pockets and might have taken the money in payment for the newspaper from the pocket in which he had placed the ring. It was a warm day, and plaintiff conceded that his hand might have been moist, thus enhancing the possibility of objects clinging to it.

The insured sought to prove a mysterious disappearance, asserting the *Levine* case as precedent. However, in holding for the company, the court observed that on the basis of the uncertainty as to the last time the insured actually had the ring in his possession, the *Levine* case was clearly distinguishable, since in that case the insured clearly remembered placing his ring on the washstand, which gave rise to a logical inference that somebody subsequently came upon the ring and took it into his possession, thus stealing it. The court ruled that such an inference did not follow from the facts of this case, observing about the "mysterious dissappearance clause":

> The purpose of the clause is not to eliminate the element of theft, but rather to make proof of theft easier for the claimant.

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[39] *Ruby v. Farmers Mutual Automobile Ins. Co.*, 79 N.W. 2d 644 (Wisc., 1956)

[40] *Deckler v. Travelers Indemnity Co.*, 94 So. 2d 55 (La., 1957)

[41] *Casey v. London & Lancashire*, 160 N.Y.S. 2d 114 (N.Y., 1956)

On further appeal,[42] the court affirmed the judgment for the company and added the following observations which should serve as helpful guides:

> Furthermore, as a matter of law, even if it were assumed that the ring was lost in a limited area and that a thorough search did not turn it up. The mysterious disappearance clause would still be inapplicable. The clause does not cover the mysterious inability to find lost property. There is a suggestion in the plaintiff's argument that the whole of the "limited area" may be regarded as the place in which the ring was deposited and that the ring may be deemed to have disappeared from that place. We find this suggestion farfetched. The ring was not intentionally deposited in the so-called "limited area" but was deposited in the plaintiff's pocket and was lost therefrom. The subsequent inability to find the property is not covered by the theft policy even with the mysterious disappearance clause in it.

The most recent case involving the mysterious disappearance clause was decided in Pennsylvania in November, 1958. That case involved the disappearance of a diamond ring through a hole in the pocket of a house dress. The result is unsatisfactory on several accounts.[43]

Mrs. Gordon had removed the ring from her finger while baking in her kitchen, and placed it in the pocket of her house dress. The house dress became soiled, and she removed it and sent it to a dry cleaner. That evening she missed the ring and she remembered having put it in the pocket of the house dress and also that there was a hole in that pocket. She and her husband and their maid searched the floors of their house for the ring and she telephoned the cleaner and learned that the ring was not in the pocket of the dress and that there was a hole in the pocket. The cleaner searched his premises and could not find the ring. Then the maid, who had helped in the search for the ring, supplied the classic clue. She left for her day off and, without notice to her employers, never returned to work.

The court approved and followed the *Sigel* case, decided several years earlier in Pennsylvania, in holding that the insured was entitled to recover on this evidence. In this case, as in the *Sigel* case, the court seems to have attached undue significance to the "presumption", to the point of obscuring the real issue, viz., whether the disappearance was in fact mysterious. The court did observe that there must be a possibility that there was a theft before what it termed the "contractual presumption" could apply, and it had no difficulty finding such a possibility in the maid's behavior.

"Mysterious Disappearance" as a "Presumption of Theft", as an "Insured Peril", and as an "Exclusion"

Perhaps the greatest source of confusion and misunderstanding surrounding the subject of "mysterious disappearance" has been the provision that a mysterious disappearance of insured property shall be presumed to be due to theft. This was, of course, immediately recognized as a "presumption" and there followed, inevitably, discussions of presumptions generally, the weight to be attached to different kinds of presumptions, and whether the mysterious disappearance presumption was or was not rebuttable — it being concluded, generally, that it was the rebuttable type of presumption.

An unfortunate consequence of the emphasis placed on weighing the effect of mysterious disappearance as a presumption is that, as we have seen, it tended to obscure the importance of first determining whether a disappearance of insured property was, in fact, a *mysterious* disappearance.

Professor Wigmore would have cut the Gordian knot and made short work of this confusion. He had characterized such a "presumption" as not really a presumption at all, but simply the rational potency of an evidentiary fact, having no legal consequence.[44]

In view of the fact that those who drafted the Residence and Outside Theft Policy fully intended that proof of the mysterious disappearance of insured property be accepted as proof of its theft,[45] it seems re-

[42] 168 N.Y.S. 2d 692 (N.Y., App. Div., 1957)

[43] *Gordon v. Eureka Casualty*, 146 A. 2d 379

[44] *Wigmore on Evidence*, (3d Ed.) §2491

[45] See footnote 7; also, the following source material: F. H. Deady: "Mysterious Disappearance Losses Under Residence Burglary, Theft and Larceny Policies—What Courts Have Held in Various Jurisdictions", The WEEKLY UNDERWRITER, December 17, 1938, p. 1249; Davis Quinn: "Mysterious Disappearance in Residence and Outside Theft Policy", The EASTERN UNDERWRITER, April 28, 1944, p. 53: "New Residence and Theft Policy—Mysterious Disappearance . . . and Other Points", The WEEKLY UNDERWRITER, May 6, 1944, p. 1064; R. E. Lee Field: "Mysterious Disappearance

markable, as well as unfortunate, that the companies should be called upon in some cases to pay losses, because the policy said "mysterious disappearance of any insured property *shall be presumed to be* due to theft," which they probably would not have had to pay if the policy had said "mysterious disappearance of insured property *equals* theft of insured property", which is exactly what was intended.

This paradox is readily explainable as resulting from attaching too much significance to the effect of mysterious disappearance as a "presumption" and too little to establishing that the disappearance was *mysterious.*

The way to resolve the dilemma was to do away with the words which had caused all the trouble. That is just what happened when, in 1956, the Broad Form Personal Theft Policy was introduced and "mysterious disappearance" was made an insured peril.

Other policy forms, referred to earlier, also include "mysterious disappearance" as a peril insured against, and the "presumed" wording is no longer employed.

The point which should be clearly understood is that mysterious disappearance as an insured peril affords exactly the same coverage as mysterious disappearance as a "presumption" of theft. The same standards apply now for determining whether a disappearance of insured property is a mysterious disappearance as applied before. It is just as though the company had said, in 1943, "The policy insures against loss by theft but we will also pay if you establish loss by mysterious disappearance" and, in 1956, "The policy insures against loss by mysterious disappearance and we will pay if you establish loss by mysterious disappearance".

Just a few words about "mysterious disappearance" as an exclusion. Undoubtedly, the 1948 revision of the Residence and Outside Theft Policy had the effect of eliminating many claims for the loss of stones from rings, and similar wording in exclusion clauses will have a similar effect. However, two questions arise. First: Did the companies really intend in 1948, and do they intend today, to rule out payment for stones lost from their settings under circumstances satisfying our definition of mysterious disappearance? Perhaps the answer is in the affirmative, on the ground that such losses are just too troublesome and produce too many claims seeking recovery for the mere losing of stones from settings.

Second: Is it sound practice to employ in an exclusion clause a characterization such as "mysterious"? Since the burden is on the insurer to establish the applicability of an exclusion, we could have a case of the insurer arguing no coverage on the basis that a disappearance is mysterious, and the insured arguing that it is not mysterious at all. This should not create any serious problem under a policy where loss by mysterious disappearance is specifically insured against, for the reason that, under such a policy, the insured must first establish a mysterious disappearance of property to bring his loss within the coverage, and the insurer may then show that mysterious disappearance of certain property is excluded.

However, consider a case where coverage is written on an "all risks" basis and mysterious disappearance losses are excluded. How would you go about persuading an insured that a loss of property, otherwise covered, is not covered because the loss was by mysterious disappearance? No cases have yet considered this point, so far as I know. Perhaps, it would be wise to avoid such a situation by having the policy worded so as to exclude loss by "disappearance" rather than by "mysterious disappearance".

Conclusion

In concluding, I want to leave with you the reminder that a "mysterious disappearance" is one involving a disappearance of property from a clearly identified location under circumstances which suggest theft as the logical explanation. That is what a "mysterious disappearance" was in 1943; that is what it is today. And, keep in mind —— in deciding whether a loss is or is not recoverable as a "mysterious disappearance" ——a mystery is something out of the ordinary; it is not an everyday occurrence.

Under the New Theft Policy", The Insurance Law Journal, January, 1945, p. 3; Annotation: "Provisions of Theft Policy as to Evidence of Loss", 169 A.L.R. 224 (1946).

Remedies Available Under Indemnity Agreements*

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The Reserve Deposit Provision of the Indemnity Agreement Merits More Widespread Adoption and Enforcement

FOR many years surety companies have been frequently reminded by the courts that they are compensated sureties, not individual sureties; that they are no longer the darling of the courts; that the rule of *strictissimi juris* no longer applies to them, and that if they expect to prevail in any suit they must take their chances on remedies, along with the rest of the business community. But sureties have not resorted to the available remedies, as much as other segments of the business world, to such remedies as exoneration, specific performance, injunctions and declaratory judgments. Instead the emphasis has been on subrogation and simple contract actions to enforce indemnity provisions.

The emphasis has been on action subsequent to the loss or expense, rather than preventive actions prior to the loss, and on the basis of clear and present liability. This may be due in some instances to an absence of suitable provisions to support such anticipatory action in the underlying contract documents. For example, many companies have no provision in their application, or indemnity agreement, stating that,

> "If the Company shall be required or shall deem it necessary to set up a reserve in any amount to cover any claim or claims under any bonds executed for undersigned, or for any reason whatsoever, undersigned will immediately on demand deposit with the company current funds in the amount of such reserve, to be held by the Company as collateral."

Yet such provisions have received the sanction of the courts for many years. In the early California case of *Showers v. Wadsworth*, 81 Cal. 270, 22 P. 663, 664 (1889), it was said, "The indemnity was against liability, and, hence, there was a right of recovery upon the contract as soon as the liability was incurred." And in *Rector, etc., of Trinity Church v. Higgins*, 48 N.Y. 532, 537, it is said,

> "The rule may be definitely drawn from numerous cases, that where indemnity only is expressed, damages must be sustained before a recovery can be had; but a positive agreement to do an act which is to prevent damage to the plaintiff, will sustain an action where the defendant neglects or refuses to do such act." (Citing many cases, as well as *Sedgwick on Damages*, 303-314)

To the objection that the amount sought was not yet certain and determined, the above court said, "That is certain which is capable of being rendered certain." In the later case of *Hume v. Hendrickson*, 79 N.Y. 117, 127, the court said the agreement was not merely to save harmless, "if that had been its purpose, very different language would have been employed, ***the right of action was complete and perfect the moment the mortgage became due and remained unpaid."

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In *MacArthur Brothers Co. v. Kerr,* 213 N.Y. 360, 365, the language of the agreement was that the indemnitor would pay "all damages for which said company*** shall become responsible***before said company or its representatives shall be compelled to pay the same." The court said, "What could be clearer than this language?" And it held payment was required, "without waiting for enforcement of this liability by payment and infliction of damages in the ordinary manner."

With these cases as background, reference can be made to more recent cases on the subject, such as *Tennant v. U. S. Fidelity & Guaranty Co.,* 17 F. 2d 38; *Standard Surety and Casualty Co. v. Caravel Industries Corp.,* 128 N.J. Eq. 104, 15 A. 2d 258; *National Surety Corporation v. Titan Construction Corp.,* 26 N.Y.S. 2d 227, aff'd 260 App. Div. N.Y. 911; *Marine Midland Trust Company v. Alleghany Corp.,* 28 F. Supp. 680; *Greenleaf v. Blakeman,* 40 App. Div. 271, aff'd sub. nom. *Greenleaf v. Schley,* 166 N.Y. 627; *McNamara v. McNamara,* 256 App. Div. N.Y. 370; *Amer. Bonding Co. v. Hotel Siwanoy,* N.Y.L.J. July 20, 1943, p. 137; *Seaboard Surety Co. v. Munro Constr. Corp.,* N.Y.L.J., June 11, 1958 (not officially reported) Trial Term, Part XXIX—Wasservogel, Spec. Referee; *Seaboard Surety Company v. Lindfore,* New York County Supreme Court, decided January 16, 1952; *Fireman's Fund Ins. Co. v. Anderson,* Superior Court, Cook County, Ill., September 27, 1957; *National Surety Corporation v. Yeskel,* Chancery Court, N.J., May 14, 1937, May 25, 1937. See also *In re Daily,* 19 F. 2d 95 and *Hartford Accident Indemnity Co. v. Flanagan,* 28 F. Supp. 415, 420.

In the case of *Tennant v. United States Fidelity and Guaranty Co.,* 17 F. 2d 38, the language of the agreement was that the indemnitor would save the surety "harmless from and against every claim, demand, liability, cost, charge, counsel fee, expense, suit, order, judgment and adjudication whatsoever, and will place the surety in funds to meet the same before it shall be required to make payment***." Regarding this language, the United States Court of Appeals for the Third Circuit said,

> "***It is also to be noted that the principals expressly agreed that they would perform all the conditions of the contract, and also agreed to place the surety company in the funds which it might require before the surety company should be required to make payment. In this particular, the contract gives the surety rights beyond those implied in law. Such a contract is legal and may be the basis of a recovery. Professor Williston says in his book on Contracts, at page 2311, as follows:
>
> 'At law, recovery on a contract of indemnity before payment of the liability is dependent on the construction of the contract. If the terms are broad enough to amount to an indemnity against liability, and not merely an indemnity against payment in discharge of liability, recovery will be allowed as soon as the party to be indemnified has incurred liability. But courts of equity, even in the absence of words expressly guaranteeing freedom from liability, as distinguished from freedom from loss, specifically enforce the obligation and compel the promisor to meet his obligation to indemnify before payment of it by the promisee.' "

Of particular interest is *Standard Surety & Casualty Co., v. Caravel Industries Corporation, supra.* This case involved a supply contract to furnish aluminum pots to the United States, for which a performance bond was given, in return for an indemnity agreement which contained a reserve deposit provision similar to that set forth above.

No deliveries were made under the contract, the government asserted a claim under the bond, whereupon a reserve was set up by the surety, and a demand for a deposit of an equal amount as collateral was made upon the principal. After an interesting discussion, citing *Bosch Magneto Co., v. Rushmore,* 85 N.J. Eq. 93, 95 A. 614, and *North v. Joseph W. North & Son,* 93 N.J.L. 438, 108 A. 244, the court said,

> "***Defendants did not agree to post collateral only if a valid claim were made, but if any claim were made and complainant found it necessary in consequence thereof to set up a reserve.****
>
> "What the parties had in mind when defendants agreed to deposit collateral was that at some distant day the liability of complainant might be established by judgment and the principal debtor, as well as defendants, be at the time insolvent. To guard against that contingency, the defendants agreed to make the deposit as soon as a serious question of liability should arise. Such a situation has now arisen."

Also of much interest is the oft-cited case of *National Surety Corporation v. Titan Constr. Corp.*, 26 N.Y.S. 2d 227, aff'd 260 App. Div., N.Y., 911, where a reserve deposit provision was also involved. The complaint alleged that there were unpaid labor and material bills in an undetermined amount; that there would be completion costs in an undetermined amount; that the proper reserve had been set up; that the defendant had refused to deposit an equivalent amount; and that plaintiff (surety) was being deprived of its security. In granting relief, the court said,

> "The very purpose of Clause 2 of the agreement is to entitle plaintiff, the moment danger of possible future liability appears, to security against any loss plaintiff may subsequently sustain if such liability matures, and to save plaintiff from being in the position of a general creditor of defendants, on a parity with their other creditors."

As helpful as these latter decisions are, they are tempered with a word of caution. Both reflect the idea that the deposit should be for purposes of collateral only, and not as a direct payment to the surety, and not with the understanding that it should be used by the surety to pay claims, at the surety's complete discretion. They strongly imply that while it is equitable, on the basis of mere liability, to enforce a specific provision for collateral, it would be inequitable to allow the actual payment of asserted but possibly unproven or unadjudicated claims.

The suits mentioned were based primarily on the equitable remedy of specific performance, which is indeed a proceeding in equity, which, in turn, implies wide discretion, and an assurance that any decree when rendered, will operate "without oppression or injustice to either party." The indications are that where the equitable remedy of specific performance is sought, the courts are likely to enforce the reserve deposit provision, but are likely to demur at the suggestion that the collateral be used, at the surety's sole discretion, for the payment of outstanding claims. In jurisdictions where the distinction between law and equity has been abolished, such as in the federal courts, this difficulty might be overcome by asking for specific performance of the collateral provision, and in the same suit requesting exoneration from liability for payment of the outstanding claims; also, in dire situations it may be necessary to couple the suit for specific performance with a request for a temporary restraining order to prevent a dissipation of the assets. See *Marine Midland Trust Co. v. Alleghany Corp.*, 28 F. Supp. 680, 684. Even in jurisdictions where a separate equity side is maintained, the equitable remedy of exoneration could be sought along with specific performance. In this way the asserted but unproven claims could be validated in the same proceeding, and paid either out of the collateral deposited, or directly to the claimants by the indemnitors.

The argument is often made both in and out of court that the collateral provision can have no validity because it is too uncertain, that it allows the surety to set up any reserve it deems necessary. It is argued that arbitrary action by the surety could wreck the business of an indemnitor; and that no one should have a blank check to demand collateral in any amount he chooses. This is not an easy argument to answer, but the best answer seems to be that the court, in the proper exercise of its duties, will guard against and prevent any excesses. The proceeding is in equity where the court has full discretion, and unless it is convinced that the reserve has been established reasonably and in good faith, it will, in its order, reduce the amount of the deposit. The reasonableness of the amount demanded can be made the subject of proof before any order or decree is issued.

A case with some relation to this subject was decided in May, 1960, in the Supreme Court, Appellate Division, First Department, *Maryland Casualty Company v. Farley*, wherein the surety sought authority to liquidate stock that had been posted as collateral for an appeal bond. The court not only held the surety was entitled to liquidate the stock, but that it could do so at times best suited to its needs rather than those of the indemnitors. This case suggests that where exoneration has not been sought, along with specific performance of the reserve deposit provision, the way to realize upon the collateral at a subsequent date might be by way of declaratory judgment.

The best argument to be made in support of the reserve deposit provision is that in the present economy the bare right to indemnity has lost much of its value, as this implies an actual loss or payment before the indemnitor is required to respond and often an insolvency has intervened. Banks, and other enterprises as well, have long

since made collateral an integral part of their routine, and thus have obtained preferred positions in insolvency proceedings, or have avoided participation in such proceedings. The time has come when it should be utilized and enforced more often by sureties as a preventive measure.

In Connection with Public Contracts, Loss Can Often be Averted by Prompt Injunctive Action

There is another form of preventive action that has been largely neglected, although this relates only to public contracts. This is where a contractor is in trouble, joint control and other cooperation has been refused, and payment of large contract balances by the government involved is imminent. In these circumstances, it is possible to institute a suit, not against the United States, or the state, but in personam against the disbursing officer, and the head of the department immediately involved.

For example, where a contract with the Department of the Army is involved, the suit, in most cases, would be instituted in the District of Columbia, and would name as defendants the Secretary of the Army and the Treasurer of the United States, as well as the prime contractor. The complaint would request that a restraining order be issued against payment to the contractor, and that a receiver be appointed to receive and hold the money pending further order of the court. It has been judicially determined that this is not a suit against the United States without its consent, and despite some difficulty in securing jurisdiction over a non-resident prime contractor, it can be done within the provisions of the Code of the District of Columbia. The procedure has been successfully employed on many occasions.[1]

Indeed, it is possible to adopt the simpler procedure of an exoneration suit naming the same defendants but here there is no assurance that the status quo will be maintained by a restraining order. In practical operation, the simpler exoneration procedure has proved as efficacious as the more laborious injunctive procedure because under both the Treasurer of the United States normally issues a stop payment order pending developments, with the result that the prime contractor becomes more cooperative.

Where there is a serious contest between a surety, and a bank claiming priority by reason of an assignment under the Assignment of Claims Act (Title 31 U.S.C.A., Sec. 203), or between a surety and a trustee in bankruptcy, to contract balances in the hands of the government, a new procedure has emerged in the United States Court of Claims. A surety may proceed by filing a complaint against the United States, and by joining the contesting party as a third-party defendant, by having him served with a suitable summons. *National Surety Company v. United States,* 132 Ct. Clms. 724, 133 F. Supp. 381; *Maryland Casualty Co. v. United States,* 141 F. Supp. 900. This procedure is authorized by 41 U.S.C.A., Sec. 114 (b), which is part of the Contract Settlement Act of 1944, 58 Stat 649, 41 U.S.C.A., Sec. 101. It must be borne in mind, however, in connection with this procedure, that close control of the status quo is lacking, since the United States Court of Claims has no injunctive power. But this lack of injunctive power may have been overcome by the recent and highly interesting decision in *Newark Insurance Company v. United States,* 169 F. Supp. 955, where the Court of Claims held that,

> "If it is made to appear that the Government's officials, after due notice of the facts giving rise to an equitable right in the plaintiff surety company, and of the plaintiff's assertion of such a right, paid out, without valid reason for so doing, the money in question to someone other than the plaintiff, the plaintiff will be entitled to a judgment."

One reason for choosing this latter procedure, over the procedure first mentioned, might be that over a period of years the United States Court of Claims has shown a disposition to favor the equitable rights of the surety in keeping with the original *Prairie State Bank* doctrine.[2]

The Assignment in the Indemnity Agreement of Plant and Equipment Has Been Greatly Reinforced by Recent Action of the United States Supreme Court

Another subject of current interest has to do with the provision in indemnity agree-

[1] *Houston v. Ormes,* 252 U.S. 469; *Mellon v. Orinaco Iron Company,* 266 U.S. 121; *Morganthau v. Fidelity & Deposit Co.,* 68 App D.C., 163, 94 F. 2d 632; *Sanborn v. Maxwell,* 18 App. D.C., 245; *Roberts v. Consaul,* 24 App. D.C., 551; *Jones v. Rutherford,* 26 App. D.C., 114; *In re Grimmage's Estate,* 69 App. D.C., 370, 101 F. 2d 695.

[2] *Modern Industrial Bank v. United States,* 101 Ct. Clms. 808; *Hardin County Savings Bank v. United States,* 106 Ct. Clms. 577; *Royal Indemnity Co. v. United States,* 117 Ct. Clms. 736, 93 F. Supp. 891.

ments relating to the surety's rights against a principal's plant and equipment in the event of a default. Most agreements contain a provision which purports to be an assignment of plant and equipment but, by and large, the provision has not been favorably regarded by the courts, especially where bankruptcy or other insolvency proceedings have occurred, and this, in turn, has often been due to the impact of state recording acts, and other state laws relating to personal property, which are principally designed to prevent secret liens or other types of rights in personal property. In other words, the assignment in the indemnity agreement has often been interpreted as a "chattel mortgage" subject to all recording provisions relating to such documents, which provisions vary depending upon the state involved. Generally speaking, unless the indemnity agreement was recorded, the surety's rights in plant and equipment prior to insolvency have been regarded as inferior to those of other creditors. *Stulz-Sickles Co. v. Fredburn Constr. Co.,* 114 N.J. Eq. 475, 169 A. 27; *Newman v. Globe Indemnity Co.,* 275 Pa. 374, 119 A. 488; *Electric Transmission Co. v. Pennington Gap Bank,* 119 S.E. 99; and the same holds true after bankruptcy. *Massachusetts Bonding & Ins. Co. v. Kemper,* 220 Fed. 847; *In re P. J. Sullivan,* 254 Fed. 669; and *In re Schilling,* 251 Fed. 466. But for a favorable and contrary ruling, see the decision of the Fourth Circuit Court of Appeals in *Hartford Accident & Indemnity Co. v. Coggins,* 78 F. 2d 471, which held that the actual taking possession of machinery and equipment perfected a previously unrecorded mortgage within the meaning of the applicable provision of the Bankruptcy Act. See *3 Collier,* 14th Ed., Sec. 924.

There have been one or two developments in this area that are worthy of careful consideration. The first is described in the case of *United States v. G. P. Fleetwood and Company,* (D.C.W.D. Pa.) (1958), 165 F. Supp. 723. In that case the surety, in opposition to a trustee in bankruptcy, sought to assert its right to contract money in the registry of the court, which it normally would be entitled to have by way of subrogation, and its express assignment. The court denied the usual right of subrogation mainly on the theory that the Uniform Commercial Code, now adopted by the Pennsylvania legislature, provides that to constitute a lien, security agreements must be recorded in accordance with the provisions of the code; that the clause in the application constitutes a security agreement; and since there was no recording in compliance with the code, the surety has no lien but is in the position of a general creditor. Reference is made in the decision to Sections 9-106, 9-301 (3), 9-302 and 9-403 of the code, under the heading of "Secured Transaction." What makes these sections more serious, as here interpreted, is that they are being applied to money, in the form of contract balances, and not merely to physical property in the form of plant and equipment. What this court has done is to apply the recording provisions of the Uniform Commercial Code, without regard to any equitable rights the surety might have to the money, independent of the express assignment contained in the application.

That the provisions of this code must be taken seriously is evident from its source. As presently printed, it is a document of some 700 pages, comprehending most of the commercial law of the country, including sales, negotiable instruments, and allied subjects, prepared under the auspices of the American Law Institute and the National Conference of Commissioners on Uniform State Laws, and it was approved by the American Bar Association in 1952. It has been adopted in at least five states, including Connecticut and Pennsylvania. Its adoption is rapidly spreading thus requiring careful scrutiny of the sections bearing on the indemnity provisions under consideration here. It must be observed that if adopted in all states, it would at least have the advantage of establishing a uniform rule regarding recordation, in place of the chaotic condition that now exists.

Another matter that requires attention in this area is the recent decision of the Supreme Court of the United States in *Armstrong v. United States,* 361 U.S. 812, 80 S. Ct. 86, 4 L. Ed. 2d 1554, a decision that is bound to have a profound effect, at least in federal courts and in bankruptcy proceedings. This was a case in which a supplier furnished materials to a prime contractor who was constructing navy personnel boats for the United States at a site in the state of Maine. The contractor defaulted and by presumed authority of contract provisions the government took over all completed and uncompleted work, and unused materials, and moved them to naval shipyards at New York, Philadelphia and Norfolk. The supplier was unpaid and he sued the United

States on the theory that the law of the state of Maine gave him a lien on the plant and equipment, and that by its actions the government destroyed the lien, by making it unenforceable, and that this constituted a taking of property without just compensation in violation of the Fifth Amendment of the Constitution.

The Supreme Court agreed:

> "***Neither the boats' immunity, after being acquired by the Government, from enforcement of the liens nor the use of a contract to take title relieves the Government from its constitutional obligation to pay just compensation for the value of the liens the petitioners lost and of which loss the Government was the direct positive beneficiary."

The argument had been made by the government that materialmen cannot acquire a lien on public work (citing *United States v. Munsey Trust Company,* 332 U.S. 234, 241), and that since under the prime contract the government had "inchoate title" to the unfinished work, the case fell within that rule. Also citing *United States v. Ansonia Brass & Copper Co.,* 218 U.S. 452. The court dismissed this argument saying that the actual terms of the prime contract did not place "inchoate title" in the government; and that, furthermore, the materialman was not a party to the prime contract, "and nothing in the record indicates that the scope of such liens is affected by contractual arrangements into which the owner of the property may have entered."

It is difficult, as always, to forecast the ultimate effect of this important decision, and the extent to which it will affect the rights of surety companies. It would seem reasonable to suppose that where by the usual rules of subrogation a surety finds itself in the shoes of a materialman, it would be entitled to the full benefit of this ruling; and if it succeeded to any prior lien right granted to the materialman by state law, attaching to the plant and equipment, such right would take precedence over any provision to the contrary in the government contract. Also, where care is taken to reinforce the assignment contained in the indemnity agreement by complying with state recording laws, and other laws relating to personal property, the surety might also have the benefit of this Supreme Court decision.

It is reasonable to expect that in the future the government will not summarily take over plant and equipment of a defaulted contractor, even though it is presently authorized to do so by the standard form of contract, until the rights of materialmen, sureties, and others, under state law, can be ascertained.

The Assignment of Earned Estimates and Retained Percentages Contained in the Indemnity Agreement Has Been Greatly Strengthened by Recent Decisions of the United States Supreme Court

There is another part of the Indemnity agreement that has been profoundly affected by action of the United States Supreme Court in recent weeks, and this is the part of the application which undertakes to assign to the surety earned estimates and retained percentages in the event of a default by the principal. This provision has been involved in endless litigation, the most significant of which resulted from an effort on the part of the federal government to assert tax liens against these same funds.

As a result of a line of decisions of the United States Supreme Court[3] culminating in the *Ball Construction Company* decision, all of which granted the prior right to the federal government on the so-called "choateness" theory, a committee was set up by this association on which the Fidelity and Surety Law Committee had two distinguished representatives, Mr. Alexander M. Heron and Mr. R. Emmett Kerrigan, with directions to study the matter and make a report. How well they did their work is reflected in the recent decisions of the United States Supreme Court in *Aquilino v. United States,* 363 U.S. 509, 4 L. Ed. 2d 1365, decided June 20, 1960, and *United States v. Durham Lumber Co.* 363 U.S. 509, 522, 4 L. Ed. 2d 1371, decided on the same date, both of which clearly reveal that the Supreme Court had been reading the committee report.

By its previous decisions the Supreme Court acknowledged that whether a fund "belonged to" a taxpayer was governed by state law, but then nullified this principle by making the controlling ruling that pri-

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[3]*United States v. Bess,* 357 U.S. 51; *United States v. Acri,* 348 U.S. 211; *United States v. City of New Britain,* 347 U.S. 81; *United States v. White Bear Brewing Co.,* 350 U.S. 1010; *United States v. Ball Construction Co.,* 355 U.S. 587.

orities in the fund are to be determined by federal law. It then said that under federal law for a lien to be valid, it must be choate, and, in the case of the surety's lien growing out of its assignment, it said the lien was "inchoate", and thus not on the same footing with the federal tax lien, at least so far as United States contracts are concerned. There is a line of cases indicating that where the United States is not the owner a different rule will apply.[4] In this line of cases it was held by the lower federal and state courts, with subsequent seeming approval by the Supreme Court in the *Bess* case, that the tax lien would apply only to funds owned by the taxpayer-contractor, and that, after default, the contractor under equitable principles, was no longer the owner.

The committee considered two courses (a) a simple amendment to the tax law providing that priorities between federal tax liens and competing claims, as well as the taxpayers property rights, would be determined by state law, or (b) the whole field would be selectively examined and appropriate action taken as to each class of lien, and this latter course was adopted by the committee.

In the *Aquilino* decision, which involved the priority of a mechanics lien, and came to the Supreme Court on certiorari from the Court of Appeals for the State of New York, the court vacated the New York decision and remanded the case with directions to determine the exact "property" interest of the taxpayer in the fund in question under the law and statutes of the State of New York. This decision seems to be in direct conflict with the *White Bear Brewing Company* case, where the "choateness" rule was applied.

In the *Durham* case a materialman asserted priority over the federal tax lien on the basis of a North Carolina statute giving him a direct cause of action against the owner for amounts due him by the general contractor. The case came to the Supreme Court on certiorari from the United States Circuit Court of Appeals for the Fourth Circuit, which had held for the materialman.

The Supreme Court affirmed on the sole ground that it had been found by the lower courts that under state law the taxpayer had no property interest in the fund; and it did this even though, at the same time, it indicated that the lower courts were "probably incorrect" in their interpretation of the North Carolina state law.

In the light of these decisions it seems clear that the so-called "choateness" rule of the *Ball Construction Company* case has been abandoned, and that, henceforth, as a practical matter, priorities will be established by state courts, or possibly by state legislatures. Any doubt on this score is dispelled by the concluding paragraph of the dissenting opinion of Mr. Justice Harlan in both cases where he says,

> "If the federal standard of choateness is thought to be an undesirable restriction on the States' freedom to regulate property relationships, the cases establishing that standard should be expressly overruled and not emasculated by dubious distinctions."

Needless to say, these decisions, taken together with the *Armstrong* decision, rendered a week later on June 27, 1960, profoundly affect the property rights of surety companies in plant and equipment, as well as contract balances, of a defaulted contract, and strongly suggest the advisability of the appointment of a study group to go over the existing provisions of standard indemnity agreements with these decisions in mind.

Recent Decisions Affecting Other Parts of the Indemnity Agreement

The books are full of decisions interpreting the various provisions of the indemnity agreement, and no useful purpose would be served by reviewing them here, especially since this task has been ably performed on several prior occasions.[5]

There are, however, one or two recent decisions bearing on the domination principle that are worthy of note:

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[4] *United States Fidelity & Guaranty Co. v. Triborough Bridge Authority*, 297 N.Y. 31, 71 N.E. 2d 226; *United States Fidelity & Guaranty Co. v. United States*, 201 F. 2d 118, 10 Cir.; *Vincent v. P.R. Mathews Co.*, 126 F. Supp. 102 (N.D.N.Y.); *Fidelity & Deposit Co. v. N. Y. Housing Authority*, 241 F. 2d 142, 2 Cir.; *Atlantic Refining Company v. Continental Casualty Co.*, 183 F. Supp. 478, W.D.Pa., 5 AFTR 2d 1387; *Aetna Casualty and Surety Co. v. Port of N.Y. Authority, S.D.N.Y.*, 182 F. Supp. 671, 5 AFTR 2d.

[5] Proceedings of Section of Insurance, 1940, Clare M. Vrooman, Various Aspects of the Surety's Right of Indemnity; 1942, Alexander Foster, Jr., Surety's Rights Under Its Indemnity Agreement; 1950, John J. Malley, Ultra Vires Aspects of Corporate Indemnity.

Wyoming Construction Co. v. Western Casualty & S. Co., 275 F. 2d 97 (10 Cir.)

This case involves the question of domination, although not in the usual way. Suit was instituted on the indemnity agreement, by a completing surety. Several defenses were interposed: (a) the principal had been excused from performance (b) the surety had not acted in good faith in taking over completion, and (c) the real defendant or party in interest which was a successor corporation was not responsible for the acts of the original principal, that it did not inherit the contract of the principal merely because it took over stock control. The court sustained a jury verdict to the effect that aside from corporate entities, the successor corporation controlled and dominated the original principal, in connection with the contract work, and in its own interests, and thus was answerable under the indemnity agreement.

Seaboard Surety Company v. Dale Construction Co., 230 F. 2d 625 (1 Cir.)

In this case the completing surety sued on the indemnity agreement. It appeared that the contractor had appealed the termination of its contract to the Armed Services Board of Contract Appeals, on the ground it was a wrongful termination, and had obtained a favorable decision from the board. On the strength of this decision of the board, the lower court held that completion by the surety was voluntary.

The court of appeals remanded the case on a strict reading of the take-over clause in the indemnity agreement. It said that under the wording of the clause, there need be no actual default by the principal; it need only appear "that Seaboard in good faith believed it was either desirable or necessary for it to take over the work in order to protect its interest as surety."

The Surety and Federal Tax Liens*

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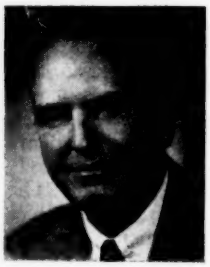
I.

"If any person liable to pay any tax neglects or refuses to pay the same after demand, the amount . . . shall be a lien in favor of the United States upon all property and rights to property, whether real or personal, belonging to such person."[1]

This section of the Internal Revenue Code gives the United States government its basic right to a lien for unpaid taxes. The section which follows provides that a lien for taxes "shall arise at the time the assessment is made".[2] "Assessment" is an internal administrative act, and requires no public notice. Indeed, even a taxpayer may know nothing of the lien at the time it arises. A federal tax lien arises, therefore, at a time and in a manner that no surety can know of the existence of such a lien.

States are powerless to change these rules, for the Supreme Court of the United States has clearly and repeatedly stated that federal law—and federal law alone—"determines the priority of competing liens asserted against the taxpayer's 'property' or 'rights to property'."[3] The doctrine of "choateness", as announced in the *United States v. City of New Britain*[4], held promise of relief for claimants competing against the federal tax lien. However, that "hope has been blighted by the more recent decisions".[5] The provisions of Section 6323 (a),[6] Internal Revenue Code, also gave some hope to competing claimants. Here, however, the Supreme Court in *United States v. Ball Construction Co.*[7] construed Section 6323 (a), Internal Revenue Code, so that the assignment to a surety as security against contingent liability was subordinated to a later arising federal tax lien.

The complicated problems growing out of the determination of priority between federal tax liens and the surety on a contractor's performance and payment bonds are well known to every attorney who represents a surety in a home-office or in the general practice. Some of the problems created by federal tax claims and liens have been considered in articles in prior issues of the Insurance Counsel Journal.[8] The



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*Paper supplied by the Fidelity and Surety Insurance Committee, Egbert L. Haywood, chairman.

[1] F.C.A. Title 26—Internal Revenue Code of 1954, Section 6321. This was formerly Section 3670 of the Internal Revenue Code of 1939.

[2] F.C.A. Title 26—Internal Revenue Code of 1954, Section 6322. This was formerly Section 3671 of the Internal Revenue Code of 1939.

[3] See the cases cited in *Aquilino v. United States*, 363 U. S. 509, 514 (1960).

[4] 347 U. S. 81 (1954).

[5] Plumb, Jr., Federal Tax Collection and Lien Problems, 13 Tax Law Review 459, 469 (1958).

[6] F.C.A. Title 26—Internal Revenue Code of 1954 Section 6323 (a). This was formerly Section 3672 of the Internal Revenue Code of 1939. This section provides: "Such lien shall not be valid as gainst any mortgagee, pledgee, purchaser, or judgment creditor until notice thereof has been filed by the collector. . .".

[7] 355 U. S. 587 (1958).

[8] Heron, Federal Tax Claims Again, or Devastation Revisited, 26 Ins. Counsel Jour. 112 (1959); Kerrigan, Recent Developments in the Contest Between the United States and the Surety for Contract Funds, 24 Ins. Counsel Jour. 104 (1957); Cross, Federal Tax Claims: The Contractor's Surety and Suppliers, 24 Ins. Counsel Jour. 384 (1957); McCahan, Jr., Tax Claims Under Payment Bonds, 21 Ins. Counsel Jour. 152 (1954); Sedwick, Withholding Tax Claims Under Payment Bonds, 20 Ins. Counsel Jour. 92 (1953); Report of Fidelity and Surety Law Committee (Rudolph, Chmn.), 19 Ins. Counsel Jour. 178 (1952); Government Tax Claims under Contract Bonds and Government Lien Rights, 18 Ins. Counsel Jour. 297 (1951)—Fisher, The Government Point of View (page 297), Bunge, The Surety Point of View (page 305). See also the Final Report of the Committee on Federal Liens of the American Bar Association, 19-23 (1959).

recent decisions in the *Aquilino*[9] and *Durham Lumber*[10] cases must now be added to the ideas expressed in the earlier articles because these decisions point to an important expansion of the emphasis on state law which formed the basis of the decision in *United States v. Bess.*[11]

II.

In *Bess* the decedent-taxpayer owed back income taxes. Tax liens had attached to his property prior to his death. When his estate was adjudged insolvent, the government attempted to enforce its federal tax lien by attaching the proceeds of eight life insurance policies which were payable to the widow on the death of the decedent-taxpayer.

The holdings of the case are: (1) the decedent-taxpayer did have "property" or "rights to property" in the cash surrender value of the policies, but (2) he had no such property interest in the proceeds of the policies. Since the decedent-taxpayer had no "property" or "rights to property" in the proceeds, then the federal tax lien could not attach to such proceeds. The liens were limited to the cash surrender values.

These precise holdings are of little value to attorneys working on legal problems of a surety. Of far greater importance is the Supreme Court's *method* of solution for it determined the rights of the decedent-taxpayer by reference to *state law*. Finding that under applicable state law he had no right to the proceeds of the insurance—such proceeds being payable only upon his death —the Supreme Court concluded that "we do not believe that Mr. Bess had 'property' or 'rights to property', within the meaning of Section 3670, to which the federal tax lien might attach".[12]

This emphasis on state law gives new hope to the surety in determination of rights in the contest between competing claimants. Federal law would be used to determine the priority between the federal tax lien and specific liens created by state law, but state law would be determinative as to whether the taxpayer actually owned either property or rights in property. If he did not, then no federal tax lien could attach.

[9]*Aquilino v. United States*, 363 U. S. 509 (1960).
[10]*United States v. Durham Lumber Co.*, 363 U. S. 522 (1960).
[11]357 U. S. 51 (1958).
[12]357 U. S. 51, 56 (1958).

III.

The problem left by *Bess* was: Is the idea to be limited to the facts presented? or does this case point to an expansion of the emphasis on state law which will be accorded wider application? Either position could be argued.

Bess was a case of insurance and property interest involved was the amount payable on the death of the taxpayer. That this death payment did not "belong" to the insured is something on which most—if not all—states agree.[13] It is not surprising in a case of this kind that the Supreme Court would conclude that state rules should not be ignored. This insurance rule of law has broad application, well beyond a determination of the federal tax lien consequences. Thus, it could be urged forcefully that the effect of the case would be strictly limited.[14]

On the other hand, the language of *Bess* was broad. The rights of the decedent in the policies were to be "defined by state law". If a state legislature has the power to define interests as either "property" or "no property", the possibility of defeating the federal tax lien now appears. The method of affecting this defeat of federal tax liens is within the power of a state legislature.

The *Aquilino* and *Durham Lumber* decisions make it clear that *Bess* will not be limited to its facts, and that state legislation will attain a new importance in deciding the priority between federal tax liens and other claimants.

Aquilino arose in New York; *Durham Lumber* came from North Carolina. In both cases the real conflict was between sub-contractors who had filed mechanics liens and the United States government which had filed federal tax liens. Had the attorneys for the sub-contractors simply argued the question of priority, it is clear from earlier cases that this question would have been determined by federal law.[15] In the briefs in both cases, however, the attorneys for the sub-contractors urged that the general contractor had no "property" or

[13]The proceeds of the usual life insurance policy cannot, of course, be acquired by the insured during his life. See dissenting opinion in *Aquilino v. United States*, 363 U. S. 509, 516 (1960), distinguishing *Bess*.
[14]This is especially true in view of the Supreme Court's handling of the cash surrender value, ignoring state rules.
[15]See footnote 3 above.

"rights to property" on which the federal tax lien could attach.

In *Aquilino* the property involved was $2200 which the owner still owed the contractor; in *Durham Lumber* it was $5250 also due from the owner under a construction contract. It was these sums which the sub-contractors and the United States government were seeking to reach with their liens. To substantiate their claim that the contractor had no property to the $2200, the attorneys for the sub-contractors in *Aquilino* advanced the New York Lien Law which provided that the funds received by a contractor from an owner for the improvement of real property constitute a trust fund in the hands of the contractor to be applied to the payment, among others, of claims of sub-contractors and that the failure to pay these claims constitutes larceny.[16] Attorneys for the sub-contractors in *Durham Lumber* claimed that the North Carolina statutes, which gave unpaid sub-contractors a direct action against the owner for sums still owing under the general contract, prevented the general contractor from acquiring a property interest in the $5250 still due.[17] Thus, the United States Supreme Court was faced with the necessity of determining the scope of *Bess*.

The Supreme Court's decisions clearly continue the emphasis which *Bess* began. In *Durham Lumber* the court affirmed the Court of Appeals for the Fourth Circuit which had held that under the North Carolina statutes the general contractor (taxpayer) had no property in the amount owing and that the government could thus recover only after the sub-contractors were paid.[18] The Supreme Court said that "since the Court of Appeals is much closer to North Carolina law than we are, and since we cannot say that the court's characterization of the taxpayer's property interests under state law is clearly erroneous or unreasonable, the judgment is affirmed".[19]

Aquilino presented an additional problem. That case came to the Supreme Court from the New York Court of Appeals which had given priority to the federal tax lien.[20] In reversing, the Supreme Court held that the New York Court of Appeals had failed "to indicate the nature of the property rights possessed by the taxpayer under state law", and that "this confilct should not be resolved by this Court, but by the highest court of the State of New York".[21] Accordingly, the Supreme Court vacated and remanded *Aquilino* to the New York Court of Appeals "so that it may ascertain the property interest of the taxpayer under state law . . .".[22]

IV.

The final chapters of this problem remain to be written by the Supreme Court. No surety was a party in either *Aquilino* or *Durham Lumber*. Neither case touches directly the "choateness" question. It would appear that once the taxpayer is found to have "property" or "rights to property", federal law will determine the priority of liens. Choateness will continue to be of importance here.

Now, however, a "threshold question" of whether the taxpayer actually has "property" or "rights to property" will be decided by reference to state law. The Supreme Court still must decide just how far a state legislature may go in taking away property interests and thus defeating federal tax liens. The Supreme Court must dispose of Mr. Justice Harlan's challenge in his dissenting opinion: ". . . . .subsequent cases must turn on the elusive distinction between diminishing a greater property interest and initially conferring a lesser one".[23] Notwithstanding the questions which remain, a turn in the road has been reached. The way is clear for sureties to consider the wisdom of state legislation in those states where the interests of sureties, contractors, sub-contractors, and materialmen in the contract funds are not clearly defined.[24]

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[16] McKinney's N.Y. Laws, Lien Law (1958 Supp.), Section 36-a.

[17] N. C. Gen. Stat., 1950, sections 44-6 to 44-12.

[18] 257 F. 2d 570 (1958).

[19] 363 U. S. 522, 527 (1960).

[20] 3 N.Y. 2d 511, 146 N.E. 2d 774 (1957).

[21] 363 U. S. 509, 515 (1960).

[22] 363 U. S. 509, 516 (1960).

[23] 363 U. S. 509, 520 (1960).

[24] I acknowledge with gratitude the suggestions given to me by Mr. Robert J. Nordstrom, Associate Dean and Professor of Law, College of Law, Ohio State University. Mr. Nordstrom edits "Reviewing the Law Reviews" for the Insurance Counsel Journal. J.P.McN.

Air Mail – Air Carrier's Liability*

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ONE of the first investigators on the scene of an air carrier accident is a representative of the Post Office Department whose job it is to salvage any remnants of air mail and to ascertain what mail had been aboard. The value of the mail may be as little as the paper on which it is written or it could conceivably equal in value the full capital of the airline. Neither the Post Office Department nor the carrier has any means of ascertaining the value until after the loss occurs. Therein lies the problem for the carrier as well as any insurer willing to underwrite whatever liability may exist for loss of the mail.

The writer has discovered no decisions to date dealing with the legal liability of an air carrier for the loss of mail as the result of an accident. There is, however, a background of case law involving surface carriers which provides some analogy if not precedent.

Generally speaking, major air carriers transport mail pursuant to the basic authority of Title IV of the Civil Aeronautics Act of 1938, and Section 1501 of the Federal Aviation Act of 1958 and the orders, rules and regulations issued thereunder. The usual carrier's Certificate of Convenience and Necessity, issued pursuant to the act, authorizes it to transport the mail and obligates it to provide adequate facilities and service for such transportation. There is no written contract with the government.

Section 405 (a) of the act authorizes the Postmaster General to make such rules and regulations as may be necessary for the safe and expeditious carriage of mail. Section 405 (b) provides that the airline shall file with the Civil Aeronautics Board and Postmaster General a statement of its schedules between the points covered by its certificate and Section 405 (d) covers the tender of mail by the Postmaster General to the carrier, which tender the carrier is required to accept.

The duty of an air carrier with regard to the mail it transports is set out in the Postal Manual, Part 531, Section 531.12. This section provides:—

> "Carriers are held strictly responsible and accountable for mail in their custody. Mail must not be left exposed on trucks or otherwise subjected to depredation or weather. Every precaution must be taken to protect the mail from fire. Mail handlers must be identified by a distinguishing cap or badge or by distinguishing clothing."

Section 531.6 authorizes the assessment of penalties for failure to observe "all applicable laws and regulations issued by the Post Office Department". It is understood that the Post Office Department has not made a practice of assessing penalties on air carriers for loss of mail in aircraft accidents.

Since there is generally no formal contract between the government and the air carrier, there is some question as to whether any action can be maintained upon a breach of contract theory. Assuming such action is maintainable it is firmly established that a mail contract is made for the general public benefit and not for the benefit of any particular sender or owner of mail. The contractor is performing a sovereign function as a public agent and is liable on the contract only to the sovereign. Neither the sender nor owner of the mail has any direct or individual interest in the mail contract or has any rights under it. *German Alliance Insurance Co. v. Home Water Supply Co.*, 226 U. S. 220 (1912); *Aetna Insurance Co. v. Illinois Central R. Co.*, 365 Ill. 303, 6 N.E. 2d 189 (1937), Cert. gtd. 301 U.S. 679, Cert. dism. 302 U.S. 652; *United States on behalf of Federal Insurance Co. v. United States Lines, Co.*, 24 F. Supp. 427 (S.D. N.Y., 1938); and *Bankers Mutual Casualty Co. v. Minneapolis, etc. Ry.*, 117 F. 434 (8 Cir., 1902).

It is also well established that the United States can sue, either in its own right or on behalf of those claiming losses (assuming, the existence of a contract). These actions generally involved an action on a performance bond required by the contract. Some, however, are direct actions upon the "con-

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tract" itself. *United States v. United States Fidelity & Guaranty Co.*, 247 F. 16 (6 Cir., 1918); *United States Fidelity & Guaranty Co. v. United States*, 246 F. 433 (9 Cir., 1917); *United States v. Atlantic Coast Line R. Co.*, 215 F. 56 (4 Cir., 1914); *United States v. American Surety Co.*, 163 F. 228 (4 Cir., 1908); and *National Surety Co. v. United States*, 129 F. 70 (8 Cir., 1904).

Where an action in contract is brought on behalf of those claiming losses, the action must be in the name of the United States and the consent of the United States must be obtained. *United States on behalf of Federal Insurance Co., supra.* The consent of the United States for third parties to sue either the carrier or on the bond is not readily given. *United States on behalf of Federal Insurance Co., supra, U. S. v. National Surety Corp.*, 309 U. S. 165, 174 (1940).

The law applicable on the question of the right of the owner of a parcel consigned to the mails to recover in tort for its loss or destruction does not have any of the certainty that exists where the action is based upon contract. The problem, while not new, has had surprisingly little consideration in recent times. Through the decisions run three threads of consideration: what is the status of the carrier in relation to the handling of the mails, and, what duties does this relationship create, and to whom are they owed?

The law is well settled that the carrier is not a common carrier as to the mail it transports, but is serving as an agency of the Government. *Atchison, Topeka & Sante Fe R. Co. v. United States*, 225 U. S. 640 (1912); *United Fruit v. United States*, 33 F. 2d 664 (5 Cir., 1929); *United States v. Atlantic Coast Line Ry. Co.*, 215 F. 56 (4 Cir., 1914); and *Bankers Mutual Casualty Co. v. Minneapolis etc. R. Co.*, 117 F. 434 (8 Cir., 1902), Cert. den. 187 U. S. 648, writ of error dism., 192 U. S. 371.

Under these authorities the carriage of the mail is a governmental function and those who do so are public agents. As a public agent, the carrier can be held for its own (its officers) negligence, but the rule of *respondeat superior* does not apply and it is not liable for the negligence of its servants, where due care has been exercised in selecting them.

The greater weight of authority supports the above view, but there are holdings to the contrary. In order to put the problem in proper perspective the cases on either side must be set out with the reason for their holdings.

The earliest case in this country to consider the problem was *Conwell v. Voorhees*, 13 Ohio 523 (1844), which held that the owners and proprietors of a stage coach who had contracted for the carriage of United States mail, were not liable to the owner for loss of a letter containing money, on the ground that such contractors were public agents, not responsible for omissions, negligence or misfeasance of those employed under them where they had employed people of suitable skill and ability. This case was followed in *Hutchins v. Brackett*, 22 N.H. 252 (1850), on the same grounds.

In *Foster v. Metts*, 55 Miss. 77, 30 Am. Rep. 504 (1877), it was held that although a rider employed by a contractor to carry mail is paid, and is liable to be discharged at pleasure by the contractor, he is an assistant and subordinate agent in the public service, and is not in the private service of the contractor; and that the contractor will not, therefore, be liable for money stolen by him from the mail.

In *Bankers Mutual Casualty Co. v. Minneapolis, St. Paul & S.S. M. Ry. Co.*, 117 F. 434 (8 Cir., 1902), Cert. den. 187 U. S. 648, writ of error dism. 192 U. S. 871, the Defendant carried mail for the United States—not under contract, but pursuant to postal regulations. The court held that in carrying the mail the railroad is not a common carrier, but is a public agent of the United States, employed in performing a governmental function and as such is liable for its own negligence, but not for the negligence or tortious acts of its subordinates or employees where due care has been exercised in selecting them.

In *Boston Ins. Co. v. Chicago, R.I. & P. R. Co.*, 118 Iowa 423, 92 N.W. 88 (1902), a mail car was wrecked and mail lost. The court assumed that the defendant's employees were negligent both in the operation of the train and in the operation of a switch. The action was commenced to recover the value of a registered mail package. The court held that the carrier was a public agent exercising a public function in carrying mail and hence not liable for the negligence of its subordinates. The discussion in this case is particularly pertinent:

> "The duty, then, whether created by statute or arising out of contract, is to the government; and railroad companies, in carrying the mails are agents of the gov-

ernment, in the exercise of a public function. Neither the sender nor the addressee of mail matter has any contract with the railway company, . . . Manifestly, the railway is neither a common, nor a private, carrier for the individual. It neither receives nor undertakes to deliver any of the letters or packages carried over its line. They are received by the government or its agents, which undertakes to deliver them at their destination. The railway company is not, as we understand it, a bailee of the matter carried by it; that is, a bailee in the ordinary sense. * *

"We are also constrained to hold, as heretofore indicated, that defendant, in carrying the mails, is neither a private, nor a common, carrier. It owed no duty to the sender or to the addressee of mail matter. The law had made it an instrumentality of government for the performance of acts in execution of functions assumed and controlled by it. It received its compensation from the government, and, at most, is a public agent or agency, discharging public duties. What is the liability of such an officer or agent? If it owes no duty to the individual, it incurs no liability to him, even though the individual may have been injured by its action or nonaction. And the mere fact that an individual has sustained injury by reason of the act of a public officer is not enough to create a right of action in that individual. * * *"

In *Aetna Ins. Co. v. Illinois Central Ry. Co.*, 365 Ill. 303, 6 N.E. 2d 189 (1936), Cert. gtd. 301 U. S. 679, Cert. dism. 302 U. S. 652, the Continental Illinois Bank & Trust Company of Chicago sent $21,974 in currency by registered mail from Chicago, Illinois to the Franklin County Coal Co. at Royalton, Illinois. The mail service was what was called "closed-pouch service", the mail sacks being stacked in the baggage car and handled by trainmen, none of whom had taken any government oath as prescribed by the postal laws to be taken by persons in the regular employ of the Postal Department. The currency shipment was stolen and an action commenced. The plaintiff had insured the bank against loss in the shipment, had paid the loss to the bank, taken an assignment and brought the action as assignee.

The plaintiff charged negligence of the defendant in handling of the mail, in supervision and superintendence of its servants, and negligence in the selection of the servants. On trial, the evidence showed the railroad to have been negligent in fact, as charged, and the jury found for the plaintiff. The Illinois Appellate Court affirmed. On further appeal, the Illinois Supreme Court reversed in a 4-3 decision. The court held that, outside of the contract with the government to carry the mails, the railroad owed no duties to anyone, saying at page 191:

"Liability *ex delicto* grows out of a want of ordinary care and skill in respect to a person to whom the defendant is under an obligation or duty to use ordinary care and skill. *Gibson v. Leonard*, 143 Ill. 182, 32 N.E. 182, 17 L.R.A. 588, 36 Am. St. Rep. 376. While this duty may exist independent of any contract, where it is dependent on a contractual relation some privity must exist between the one inflicting the injury and the plaintiff. *National Iron & Steel Co. v. Hunt*, 312 Ill. 245, 143 N.E. 833, 34 A.L.R. 63."

The reasoning of the court is worthy of note because of the practical considerations involved. The court said, at page 193:

"We are of opinion that, when a letter is mailed, it is from then on in the exclusive control of the government; that its transportation, guarding, and delivery are governmental functions; and that whoever performs those functions, whether carefully or otherwise, is in the service of the government. With some distinctions between land grant roads and others, the railroads are required to receive all mailable matter in such containers as the government may provide or prescribe and to handle and transport it in accord with contracts the terms of which are prescribed by law and as directed by federal statute and general orders of the Postmaster General. These contracts between the post office department and the railroads imposed duties the breach of which may give rise to liabilities, either *ex contractu* or *ex delicto*, but no individual member of the public is a party to such contract nor was any such contract made for his benefit. Presumably the government prescribes rules which will reasonably safeguard valuable mail, but as a sovereign the United States government need not do so but may handle the matter in such way as it sees fit. If any such rule of accountability as is here contended for is to be enforced, justice would require some notice to the railroad as to the val-

ue of the parcels being handled. One mail sack may be so valuless as to require no guarding at all, while another, indistinguishable from it, might need a company of soldiers. The value of the contents of an ordinary looking mail pouch might even equal the full capital of the railroad required by law to handle it, yet under the rule sought to be enforced that capital might be wiped out through the negligence of a servant with no knowledge on the part of the railroad that it had assumed any such extreme hazard and with no reasonable opportunity to take precautions commensurate with the burden imposed. Such a rule would be entirely unreasonable, if enforced without previous notice, and, if enforced after due notice to the carriers, it would unreasonably burden the public through a necessarily sharp increase in rates for transporting the mail. One desiring to transport a valuable parcel may choose his own means. He may use a special messenger or ship by freight, express, or by mail. If he chooses to commit his errand to the government, he becomes bound by the government's selection of agents and contracts with the forwarding companies, and he cannot go back of those contracts to have recourse against such agencies as the government has seen fit to employ."

The minority view, which would allow recovery in tort, where the negligence was that of an employee, is first found in the case of *Sawyer v. Corse*, 17 Gratt. 230 (Va., 1867) which involved the liability of a contractor carrying the mail for loss of a letter containing bank notes, due to the negligence of his private agent or servant. The court held the contractor liable since the employees "cannot be said to be the agents of the government, which does not know them, does not appoint them, does not control them, does not pay them, and has nothing to do with them." This case was disapproved in the *Foster* case cited earlier.

In *Central R. & B. Co., v. Lampley*, 76 Ala. 357, 52 Am. Rep. 334 (1884), the action involved registered mail which the railroad carried under contract. The court held that the railroad was a public agent, but that its employees are not. The court reasoned that they were employed in the general business of transportation and the incidental service of carrying the mails did not impart to them the character of public agents. This case was considered and disapproved in the *Bankers' Mutual case* cited previously.

The case cited by the dissent in the *Aetna* case, considered previously, as the basis for holding the carrier liable for mail lost through the negligence of its employees was in fact a suit for personal injuries suffered by a railway mail clerk. *Barker v. Chicago, Peoria & St. L. Ry. Co.*, 243 Ill. 482, 90 N.W. 1057 (1909). The distinction is obvious. While the court considered and approved the *Sawyer* and *Lampley* cases to defeat the railroad's defense that it was a public agency, its holding on the point was not necessary as it pointed out at page 1059:—

> "Whether or not, in a strict sense, the relation of carrier and passenger exists between the railroad and the postal clerk, courts hold with substantial unanimity that a postal clerk upon a train is entitled to the same measure of care as an ordinary passenger for hire."

In *Skaggs v. Missouri-Kansas-Texas Railroad Co.*, 228 Mo. App. 808, 73 S.W. 2d 302 (1934) the plaintiff shipped as first class mail, 4,700 baby chicks. En route, through the negligence of a railroad station agent, at a mail transfer point, the chicks were suffocated and died. In an action sounding in tort, against the railroad, Skaggs was allowed recovery. An appellate court affirmed the judgment, but no appeal was taken to the highest court of the state. The court held that the railroad was liable for the negligence of its employee on the grounds that it was not a public agency, but rather an independent contractor with the government. The court relied on the case of *Sawyer v. Corse, supra.* It further pointed out that the duties of the employee in handling the mail were only incidental to his duties as an employee of defendant.

In the light of the *Aetna* case it is significant to note that the mail carrier in this case knew what was being transported and therefore could very easily have protected itself against possible loss or damage.

In a case cited for support in the *Skaggs* decision, *Pryor Brown Transfer Co. v. Gibson*, 154 Tenn. 260, 290 S.W. 33, 51 A.L.R. 193 (1926), the plaintiff, Gibson, suffered personal injuries as a result of a collision between a mail truck of defendant and a car in which she was riding. Defendant claimed that it was a public agent and hence not liable for the negligence of its employee. The mail was carried under contract. The court held defendant liable relying on the *Bark-*

er case. Of interest here is the tacit admission by the court that there is a distinction between cases involving the loss of mail matter and those for personal injuries. The court said at page 197, (51 A.L.R.):

> "Without undertaking to draw a distinction between a case like the one involved and one where mail is lost or stolen, we are unwilling to extend the rule, relied upon by the company, to a case of this kind. * * *"

The considerations advanced by the Illinois Supreme Court in the *Aetna Insurance Company* decision have equal application to the problem confronting the air carrier. It might also be noted that modern air express and air freight facilities make it possible for the public to ship valuables or valuable documents with full common carrier liability available upon payment of the applicable rate based upon declared value. The carrier in such a situation is apprised in advance of the values at risk and is compensated for assuming the greater risk.

Clearly the better reasoned decisions, as well as the weight of authority would sustain the non-liability of an air carrier for negligent loss of mail.

"Who Is 'The Insured'" Revisited

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THE lawyers who crossed on R.M.S. Queen Elizabeth for the American Bar Association's meetings in London in 1957 were favored on shipboard with several interesting papers, one of which enlisted uncommon advance interest because of its title: *"Inchmaree Revisited"*. Rumors and speculations were rife concerning the mysterious *"Maree"* to be presented for the "revisitation" by John M. Aherne.[1]

In keeping, however, with the international and seagoing surroundings, it turned out that *"Inchmaree"* was the name of a vessel, that *"The Inchmaree"* was the name of an important (and appropriately English) case[2] in ocean marine insurance law, and that the proposed "revisitation" pertained to the *"Inchmaree Clause"* which was "introduced to fill the gap in the hull coverage needed by vessel owners, found to exist as a result of the 1887 decision in The Inchmaree".[3]

Here, we, like John Aherne, are "revisiting" the interpretation by the courts of a very "mysterious" term insurance (albeit liability rather than hull): "the insured"[4]; not "who done it" but "who is it"?

The reason for the "revisitation" requires that we reverse the accepted practice so as to put the punch line *first*, rather than *last*. The punch line is this: the term "the insured" means, and means *only*, the *person claiming coverage*, or (to put it another way) *only* the person coverage for whom is the issue. So, Whiteacre has an accident while driving Blackacre's automobile with Blackacre's permission in the business of Whiteacre's employer, Blueacre, and the coverage question arises under Blackacre's liability policy which covers Blackacre as named insured and Whiteacre and Blueacre as omnibus insureds. As to any claim against Blackacre, *he* is "the insured"; as to any claim against Whiteacre, *he* is "the insured"; as to any claim against Blueacre, *he* is "the insured".

When the courts find this term in the "insuring agreements", they have no trou-

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Mr. Risjord and Miss Austin are the co-authors of "Automobile Liability Insurance Cases" published in 1957 and supplemented to October, 1960.

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[1] Of the New York bar, then chairman of the Marine and Inland Marine Insurance Law Committee, and now member of the Council, of the Section of Insurance, Negligence and Compensation Law of the American Bar Association.

[2] *The Inchmaree (Thames & Mersey Insurance Company v. Hamilton)*, 12 App. Cas. 484.

[3] 1957 *Proceedings, Section of Insurance, Negligence and Compensation Law, American Bar Association* 222, 224.

[4] Most automobile liability policies substantially define the "unqualified word 'insured'" as "including the named insured" and "also including any person while using the automobile and any person or organization legally responsible for the use thereof", with certain restrictions not of interest here.

ble understanding who is meant. For instance, the company will "pay on behalf of the insured such sums as the insured becomes obligated to pay as damages" and "the company will defend the insured". The courts know that, here, "the insured" means the person against whom claim is made, suit is brought, or judgment is obtained.

When the courts find this term in the "conditions" of the policy, they have little difficulty. Where "the insured" must cooperate with the company, the courts have not been bothered very much with the question whether one insured who cooperates is denied coverage because another does not.

Where the courts have trouble is with the "exclusions", and especially the employee exclusion.[5] Is one insured denied coverage for injury to an employee of another insured? The answer is "No", not under the employee exclusion.[6]

From a date at least no later than 1940, it was clearly understood by the insurance companies participating in the standard provisions program that, as stated above, "the insured" meant *only* the person claiming coverage, and that the employee exclusion denied coverage to *any* insured *only* with respect to injury to *his* employee. By 1954, a majority of the reported decisions was to the contrary. Ironically, this is the only known situation where many of the courts persist in erring in *favor* of the insurance companies!

As a result, in 1954, the present writers, in "Who Is 'The Insured' ",[7] asserted that "the insured" was *only* the person claiming coverage. The 1955 revisions of the standard provisions promulgated by the National Bureau of Casualty Underwriters and the Mutual Insurance Rating Bureau carried a new condition[8] labeled "Severability of Interests", intended to express the purpose formerly implied and to avoid further erroneous decisions on this subject. The 1956 and 1958 standard *family automobile* policies and the 1959 *special* and *package* automobile policies (which largely supplanted the 1955 standard provisions for family-private passenger car risks) expressed the purpose even more clearly.[9]

After the 1955 introduction of "severability of interests", the present writers, in a later version of *"Who Is 'The Insured' "*,[10] reasserted their earlier position, pointing out that the 1955 Severability of Interests condition merely reaffirmed the previous intention of the underwriters.

With the thought that the insurance companies should *not* deny coverage "When the Underwriters Intended to Afford Coverage", a discussion of the matter was included in papers by one of the present writers delivered at the convention of the Federation of Insurance Counsel at Houston, Texas, on August 22, 1956[11] and at the convention of the American Bar Association in Dallas, Texas, on August 28, 1956.[12]

Now, six years after our first "visit" and five years after our second "visit", some courts are still denying coverage where coverage exists, hence this "revisit". Since this is a "revisit", no mention will be made here of cases discussed in the first two "visits".[13] It should be noted that, while some of these later cases involved the 1955 standard provisions with the "severability of interests" condition,[14] none has involved the 1958 and 1959 versions[15] (whether because they are too clear to be litigated or too recent to involve reported cases, quaere).

In 1957, shortly after the second of the

[5]Most automobile liability policies substantially exclude injury, etc., to any employee of *the insured* arising out of and in the course of his employment.

[6]Under some circumstances, a person who, so far as the employee exclusion is concerned, would have coverage for injury to another person may be denied coverage because of another provision of the policy (formerly an exception in the omnibus clause and now an independent exclusion) which denies coverage to a person other than the named insured with regard to injury to a co-employee where both are employees of a common employer and the injury arises out of the use of the automobile in the business of such employer. Be it understood that the discussion here does not pertain to that "cross-employee" exception unless the reference to it is express.

[7]5 *Federation of Insurance Counsel Quarterly* 52 (October 1954); 55 *Best's Insurance News* No. 7 (November 1954) 103, No. 8 (December 1954) 93; *The Weekly Underwriter* (October 23, 1954) 1010, (October 30, 1954) 1068; 5 *Law Review Digest* (November-December 1954) 44.

[8]"The term 'the insured' is used severally and not collectively • • •".

[9]"The insurance • • • applies separately to each insured against whom claim is made or suit is brought • • •". This more explicit expression of the same answer to "Who Is 'The Insured' " will undoubtedly be adopted for non-family or commercial or public vehicle risk when the 1955 standard provisions are next revised.

[10]XXIV *University of Kansas City Law Review* 65 (Fall Issue 1955).

[11]*"Underwriting Intent"*, 7 *Federation of Insurance Counsel Quarterly* 41 (Fall 1956); *Insurance Advocate* (August 25, 1956) 11.

[12]*"The Automobile Liability Policy Today"*, 1956 *Proceedings, Section of Insurance Law, American Bar Association*, 61, 90-91.

[13]Footnotes 7 and 10, *supra*.

[14]Footnote 8, *supra*.

[15]Footnote 9, *supra*.

earlier "visits", the present writers, in their work known as *"Automobile Liability Insurance Cases"*, with what is perhaps an obsession with this subject, organized its "Outline of Cases" in such a way as to set forth under the heading "Who Is 'The Insured' " references to the appropriate cases, under such a variety of chapters as the Trailer Exclusion, the Employee Exclusion, the Workmen's Compensation Obligations Exclusion, the Property Owned By, Rented To, In Charge Of or Transported By The Insured Exclusion, the Severability of Interests provision, and the Financial Responsibility Laws, Cooperation, Notice of Accident, Claim or Suit Conditions, pertaining to the question "Who Is 'The Insured' ".

Since the question is most pertinent with respect to the employee exclusion, this article will confine itself to that subject, omitting reference to the cases under the other exclusions[16] and the conditions of the policy. The organization of the case references here will follow[17] that used in our *"Automobile Liability Insurance Cases"* and (for the convenience of such of the readers as use it) each citation will include the number of the case in that work.

WHO IS "THE INSURED"?
Coverage for named insured for
Injury by named insured to
Employee of named insured

There are three new cases on this simple question.[18] Each properly held that there was no coverage for the named insured for injury by him to *his* employee.

WHO IS "THE INSURED"?
Coverage for named insured for
Injury by named insured to
Employee of omnibus insured

There are no new cases on this question.

WHO IS "THE INSURED"?
Coverage for named insured for
Injury by omnibus insured to
Employee of named insured

There are five new cases on this question.[19] Each properly held that there was no coverage.

WHO IS "THE INSURED"?
Coverage for named insured for
Injury by omnibus insured to
Employee of omnibus insured

There is one new case on this question.[20] It properly held that there was coverage.

WHO IS "THE INSURED"?
Coverage for named insured for
Injury by that named insured to
Employee of another named insured

There are no new cases on this question.

WHO IS "THE INSURED"?
Coverage for named insured for
Injury by another named insured to
Employee of first named insured

There are no new cases on this question.

WHO IS "THE INSURED"?
Coverage for omnibus insured for
Injury by named insured to
Employee of named insured
or
Employee of such omnibus insured

There are no new cases on either of these questions.

WHO IS "THE INSURED"?
Coverage for omnibus insured for
Injury by such omnibus insured to
Employee of such omnibus insured

There is one new case on this question.[21] It properly held that there was no coverage.

WHO IS "THE INSURED"?
Coverage for omnibus insured for
Injury by such omnibus insured to
Employee of another omnibus insured

There are no new cases on this question.

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[16]The exclusion of "any obligation for which the insured or any carrier as his insurer may be held liable under any workmen's compensation" etc. law may be ingnored because, while it is often referred to by the courts in cases involving "Who Is 'The Insured' ", not a single one of those cases actually involved the assertion of an obligation under the workmen's compensation law!

[17]With some consolidation and rearrangement of titles for brevity here.

[18]*Employers' Liab. Assur. Corp. v. Owens*, 78 So. 2d 104 (Fla. 1955), R. & A. Case No. 920; *Di Stefano v. Branco*, 156 N.E. 2d 682 (Mass. 1959), R. & A. Case No. 1757; *Rodgers v. Mikolajczak*, 105 N.W. 2d 25 (Mich. 1960), R. & A. Case No. 2077.

[19]*Arceneaux v. London Guar. & Acc. Co.*, 87 So. 2d 343 (La. App. 1956), R. & A. Case No. 788; *Jackson v. American Auto. Ins. Co.*, 103 So.2d 304 (La. App. 1958), R. & A. Case No. 1624; *Campbell v. American Farmers Mut. Ins. Co.*, 238 F.2d 284 (C.A. Eighth Cir. 1956), R. & A. Case No. 792; *Erie Railroad Co. v. American Auto. Ins. Co.*, 36 N.J. Super. 159, 114 A.2d 873 (1955), R. & A. Case No. 927; *Clinchfield Railroad Co. v. U.S.F. & G. Co.*, 160 F. S. 337 (U.S.D.C.E.D. Tennessee N.D. 1958), affirmed 263 F.2d 932 (C.A. Sixth Cir. 1959), R. & A. Case No. 1592.

[20]*Motor Vehicle Cas. Co. v. Smith*, 247 Minn. 151, 76 N.W.2d 486 (1956), R. & A. Case No. 807.

[21]*Kelly v. U.S.F. & G. Co.*, 76 So.2d 116 (La. App. 1954), R. & A. Case No. 368.

WHO IS "THE INSURED"?
Coverage for one omnibus insured for
Injury by another omnibus insured to
Employee of first omnibus insured

There are no new cases on this question.

WHO IS "THE INSURED"?
Coverage for omnibus insured for
Injury by such omnibus insured to
or
Injury by another omnibus insured to
Employee of named insured[22]

There are nineteen new cases on these two questions.[23] Fourteen *properly* decided either (a) that the omnibus insured *had* coverage for an injury by him to an employee of the named insured, (b) that one omnibus insured *had* coverage for an injury by another omnibus insured to an employee of the named insured, or (c) both.[24] Five *incorrectly* decided either (a) that the omnibus insured had *no* coverage for an injury by him to an employee of the named insured, (b) that one omnibus insured had *no* coverage for an injury by another omnibus insured to an employee of the named insured, or (c) both.[25]

Of the fourteen "correct", and the five "incorrect", new cases on these two related questions, we will discuss only the five "incorrect" cases and those two "correct" cases which involve "Severability of Interests", either academically or because the policy carried such provision.[26]

American Fidelity v. St. Paul-Mercury[27]

The unfortunate decision in the first of these "new" cases acquired an importance beyond its merits because of the eminence of the judge who wrote the opinion. The opinion was written for the Fifth Circuit by The Honorable John R. Brown, who was then new to the court but has become widely recognized as one of the outstanding judges on the federal bench, famous among bench and bar alike for his erudition as expressed in his masterful literary style and his entertaining choice of words and expressions. This early decision was "unsound" and the misfortune has compounded because (as we will see) his high standing has since led at least one other court into great (not to say "blatant") error in unwarranted reliance upon his opinion.[28] *American Fidelity v. St. Paul-Mercury* was governed by Alabama law (since the federal jurisdiction was diversity and the policy was issued and the accident occurred in Alabama) and was an action for a declaratory judgment brought by the general liability insurer of a contractor against the automobile liability insurer of a trucker. The trucker was delivering to the contractor rolls of wire mesh consigned to the contractor. Employees of the contractor, in un-

[22]It will be noted that the new cases heretofore cited were correct. It is these factual situations which have caused the trouble.

[23]The two questions are joined here for convenience and because the courts appear not to have distinguished between them.

[24]*Pleasant Valley Lima Bean Growers and Warehouse Ass'n. v. Cal-Farm Ins. Co.*, 142 Cal. App.2d 126, 298 P.2d 109 (1956), R. & A. Case No. 156; *Leonard v. Union Carbide Corp.*, 180 F.S. 549 (U.S. D.C.S.D. Indiana I.D. 1960), R. & A. Case No. 1955; *Pullen v. Employers Liab. Assur. Corp.*, 89 So.2d 373 (La. 1956), R. & A. Case No. 932; *Spurlock v. Boyce-Harvey Machinery, Inc.*, 90 So.2d 417 (La. App. 1956), R. & A. Case No. 132; *Stewart v. Liberty Mut. Ins. Co.*, 256 F.2d 444 (C.A. Fifth Cir. 1958), R. & A. Case No. 1603; *Travelers Ins. Co. v. American Fid. & Cas. Co.*, 164 F.S. 393 U.S.D.C.D. Minnesota 3 D. 1958), R. & A. Case No. 1667; *General Aviation Supply Co. v. Ins. Co. of N. A.*, 181 F.S. 380 (U.S. D.C.E.D. Missouri E.D. 1960), R. & A. Case No. 1969; *Maryland Cas. Co. v. New Jersey Manufacturers Cas. Ins. Co.*, 28 N.J. 17, 145 A.2d 15 (1958), R. & A. Case No. 1398; *Greaves v. Public Service Mut. Ins. Co.*, 5 N.Y.2d 120, 155 N.E.2d 390, 181 N.Y. S.2d 489 (1959), R. & A. Case No. 935; *City of Albany v. Standard Acc. Ins. Co.*, 7 N.Y.2d 422, 165 N. E.2d 869, 198 N.Y.S.2d 303 (1960), R. & A. Case No. 1816; *Travelers Ins. Co. v. Buckeye Union Cas. Co.*, 160 N.E.2d 874 (Ohio C.P. 1959), R. & A. Case No. 1866; *Employers Liab. Assur. Corp. v. Liberty Mut. Ins. Co.*, 167 N.E.2d 142 (Ohio C.P. 1959), R. & A. Case No. 2008; *Cimarron Ins. Co. v. Travelers Ins. Co.*, 355 P.2d 742 (Ore. 1960), R. & A. Case No. 2085; *Canadian Ind. Co. v. State Auto. Ins. Ass'n.*, 174 F.S. 71 (U.S.D.C.D. Oregon 1959), R. & A Case No. 1837.

[25]*American Fidelity & Casualty Co. v. St. Paul-Mercury Ind. Co.*, 248 F.2d 509 (C.A. Fifth Cir. 1957), reversing *St. Paul-Mercury Ind. Co. v American Fidelity and Casualty Co.*, 146 F.S. 39 (U.S D.C.M.D. Alabama N.D. 1956), R. & A. Case No. 503; *Fireman's Fund Ind. Co. v. Mosaic Tile Co.*, 115 S.E.2d 263 (Ga. 1960), R. & A. Case No. 2051; *Travelers Ins. Co. v. Ohio Farmers Ind. Co.*, 262 F. 2d 132 (C.A. Sixth Cir. 1958), affirming 157 F.S. 54 (U.S.D.C.W.D. Kentucky L.D. 1957), R & A Case No. 1538; *Simpson v. American Auto. Ins. Co.*, 327 S.W.2d 519 (Mo. App. St. Louis 1959), R. & A. Case No. 1877; *Transport Ins. Co. v. Standard Oil Co. of Texas*, 337 S.W.2d 284 (Tex. 1959), reversing *Standard Oil Co. of Texas v. Transport Ins. Co.*, 324 S.W. 2d 331 (Tex. Civ. App. 1959), R. & A. Case No. 1802.

[26]The cases will be discussed substantially in the chronological order of their appearance, regardless of result.

[27]*American Fidelity & Casualty Co. v. St. Paul-Mercury Ind. Co.*, 248 F.2d 509 (C.A. Fifth Cir. 1957), reversing *St. Paul-Mercury Ind. Co. v. American Fidelity and Casualty Co.*, 146 F.S. 39 (U.S.D.C. M.D. Alabama N.D. (1956), R. & A. Case No. 503.

[28]*Transport Ins. Co. v. Standard Oil Co. of Texas*, 337 S.W.2d 284 (Tex. 1959), R. & A. Case No. 1802.

loading the wire mesh from the truck, injured the truck driver. The injured truck driver sued the contractor and, in the declaratory judgment proceedings between the insurers which followed, the question was whether the automobile policy covered the contractor for liability for injury to the truck driver who was an employee of the trucker, the named insured under the automobile policy. The district court held that there was coverage, "persuaded that the better existing authority *** is to the effect that *** the words 'the insured' contained *** [in the employee exclusion] operate to exclude coverage only in those cases in which the injured party is an employee of the insured claiming coverage ***".[29]

On appeal, Judge Brown, speaking for the Fifth Circuit, held otherwise,[30] persuaded as to Alabama law[31] by *McDowell*.[32] *McDowell* correctly decided that the cross-employee exception to the omnibus clause precluded coverage for one employee of the named insured with regard to injury to another employee of the named insured. Since that case pertained to another provision of the policy involving a situation entirely different, we feel that it had no application to Judge Brown's question.[33]

The automobile policy before Judge Brown did not contain the new (1955) severability of interests provision, but his attention was called to the second "visit"[34] of the present writers to *"Who Is 'The Insured'"* in which we asserted that the addition of that provision was merely an expression of the previous implied but not stated intention of the underwriters. In the half-light, then, of the inapplicable *McDowell*, Judge Brown spoke of our second "visit" to *"Who Is 'The Insured'"* as "primarily to shore up the authors' conclusions that the new *** Severability of Interests *** [condition] does not expand coverage because it has always been the *underwriters'* intent that the Employee Exclusion clause should be construed as limiting it to an employee of the particular insured (named or omnibus) claiming the coverage. Exercising the advocate's privilege of asserting what the law ought to be, rather than what it is, the authors candidly acknowledge that their thesis is followed *** [in two jurisdictions], but is rejected in *** [four others] with adverse indications in *** [two others] ***".[35]

Judge Brown then went on to insist that, instead of re-enforcing the assertion of the present writers that the "underwriting intent" had always been that the term "the insured" in the employee exclusion and elsewhere means *only* the person claiming coverage, the severability of interests condition rather "re-enforces *** [the court's] conviction that meeting the insurance needs of the parties and indeed, at times, overcoming the effect of adverse or unsound court decisions, presents factors 'to be assayed by underwriters whether they sit at Lloyd's Coffee House' *** or elsewhere. Courts are not to remake the contract".[36] Thus, with picturesque and plausible argument, directed, in part, to protecting the named insured against higher premiums which would be required if the omnibus insured were here given coverage for injury to the employee of the named insured, the Fifth Circuit opinion became the first new "no coverage" decision.

It seems interesting that the *next* time the Fifth Circuit considered this question, the opinion was again by Judge Brown and this time he held that there *was* coverage!

Stewart v. Liberty Mutual[37]

This time the Fifth Circuit was concerned with Louisiana law involving coverage for the driver of a truck under the omnibus clause of the automobile policy for injury to (or the death of) another employee of a common employer (the named insured). Here Judge Brown, in a short opinion, properly following Louisiana law[38] and distinguishing *American Fidelity v. St. Paul-Mercury*[39] as based on Alabama law,[40] held

[29] *St. Paul-Mercury Ind. Co. v. American Fidelity & Casulaty Co.*, 146 F.S. 39, 43-44 (U.S.D.C.M.D Alabama N.D. 1956), R. & A. Case No. 503.

[30] *American Fidelity & Casualty Co. v. St. Paul-Mercury Ind. Co.*, 248 F.2d 509 (C.A. Fifth Cir. 1957), R. & A. Case No. 503.

[31] "Sound[ing] a special caveat" that the result was "for Alabama alone", 248 F.2d 513, footnote 7 of the opinion.

[32] *McDowell v. U.S.F. & G. Co.*, 260 Ala. 412, 71 So.2d 64 (1954), R. & A. Case No. 786.

[33] *McDowell* was not mentioned by the Alabama U. S. District Judge in his opinion below, 146 F.S. 39.

[34] Footnote 10, *supra*.

[35] 248 F.2d 515, footnote 9 of the opinion.

[36] 248 F.2d 518.

[37] *Stewart v. Liberty Mutual Ins. Co.*, 256 F.2d 444 (C.A. Fifth Cir. 1958), R. & A. Case No. 1603.

[38] *Pullen v. Employers' Liab. Assur. Corp.*, 89 So. 2d 373 (La. 1956), R. & A. Case No. 932.

[39] *American Fidelity & Casualty Co. v. St. Paul-Mercury Ind. Co.*, 248 F.2d 509 (C.A. Fifth Cir. 1957), R. & A. Case No. 503.

[40] The distinction on that ground was sound, even though, as previously noted, the court's views of Alabama law were based upon inapplicable *McDowell v. U.S.F. & G. Co.*, 260 Ala. 412, 71 So.2d 64 (1954), R. & A. Case No. 786.

that the Employee Exclusion did not preclude coverage for the omnibus insured driver for injury to an employee of the named insured, but that the Cross-Employee provision did, since driver and injured were co-employees of a common employer.

Judge Brown cited the second "visit"[41] of the present writers to *"Who Is 'The Insured'"* for the proposition that the cross-employee exception "came into being to meet this precise situation and to strengthen the force of the 'employee exclusion'".[42] In fact, our second "visit" emphasized that the cross-employee exception would have been largely unnecessary had the underwriters intended that the employee exclusion preclude coverage for an omnibus insured with respect to an injury to an employee of the named insured.[43]

Travelers Insurance v. Ohio Farmers[44]

This was likewise a declaratory judgment proceeding between the general liability insurer of the consignee and the automobile insurer of the truck, where the truck driver was injured by employees of the consignee unloading the truck. After stating that there were no Kentucky cases[45] and after citing some of the earlier decisions elsewhere, the district court held that the consignee had no coverage under the automobile policy for injury to the truck driver-employee of the named insured under the automobile policy caused by the negligence of the employees of the consignee in unloading the truck, since the employee exclusion of the automobile policy "did not extend coverage for injuries to an employee of the named insured or to additional insureds, both of whom are included in the unqualified word 'insured' as defined in the policy".[46] On appeal, the Sixth Circuit affirmed, citing two early cases to support the proposition that "The true construction of *** [the automobile] policy is that no employee of the named insured engaged in the named insured's business can recover against any one included as an additional insured".[47] We suppose that the Sixth Circuit meant, not (what it said) that the omnibus insured could not *be liable*, but merely that the omnibus insured had *no coverage* under the automobile policy, for injury to an employee of the named insured. Neither opinion mentioned severability of interests.[48]

Simpson v. American Auto[49]

Another of these new "no coverage" cases involved a declaratory judgment proceeding between (among other parties) the general liability insurer of the consignor and the automobile insurer of the truck, where the truck driver was injured by an employee of the consignor loading the truck. The St. Louis Court of Appeals held that the negligent employee of the consignor had no coverage under the automobile policy for injury to the truck driver-employee of the named insured under the automobile policy caused by the negligence of the employee of the consignor in loading the truck.

The general liability insurer had argued that "a policy covering an additional insured or insureds is in legal effect two policies of insurance; one a contract between the insurer and the named insureds and the other a contract between the insurer and the additional insureds and even though one of them shall be denied coverage, that alone will not prevent coverage of the others, despite the fact that the additional insureds' coverage may be broader than the named insureds'". The court responded, "It seems to us that the proposition contains its own condemnation. There is only one contract of insurance contained in *** [the automobile] policy and it must be construed as a whole. The additional insureds cannot claim coverage under the omnibus clause, which gives them coverage as additional insureds through definition of insureds, and then seek to ignore that very definition that gives them coverage, when considering the exclusion clause. The contention *** is unsound".[50]

Of course there were not two policies, but the interests of the various insureds were several and separate. If an omnibus insured has coverage with regard to injury to an employee of the named insured, he does not have "broader" coverage than the named insured, even though the named insured has no coverage with respect to that injured individual. The coverage for the omnibus

[41]Footnote 10, *supra*.
[42]256 F.2d 445.
[43]XXIV *University of Kansas City Law Review* 73.
[44]*Travelers Ins. Co. v. Ohio Farmers Ind. Co.*, 262 F.2d 132 (C.A. Sixth Cir. 1958), affirming 157 F.S. 54 (U.S.D.C.W.D. Kentucky L.D. 1957), R & A Case No. 1538.
[45]157 F.Supp. 58.
[46]157 F.S. 60.
[47]262 F.2d 133.
[48]The clause was probably not included in the policy under review.
[49]*Simpson v. American Auto. Ins. Co.*, 327 S.W.2d 519 (Mo. App. St. Louis 1959), R. & A. Case No. 1877.
[50]327 S.W.2d 531.

insured is, so far as the employee exclusion is concerned, the same as that of the named insured. Each has coverage with regard to injury to employees of the other and all others and neither has coverage with regard to injury to *his own* employees. The opinion did not mention severability of interests.[51]

General Aviation v. Ins. Co. of N. A.[52]

This case pertained to an aircraft liability policy issued in Ohio to an aircraft company. The policy provisions involved, including a severability of interests clause, were identical to those of the automobile policy. While an employee of an aviation supply company and an employee of the aircraft company were in the insured airplane of the aircraft company, and both were engaged in the course of their respective employments, an accident injured the employee of the aircraft company. He brought suit against the aviation supply company and its employee, alleging that that employee was flying the airplane. In a declaratory judgment action by the aviation supply company against the aircraft company's insurer, the district court held that the aviation supply company had coverage under the omnibus clause of the aircraft liability policy for the injury alleged to have been caused by its employee to the employee of the named insured aircraft company. The district court relied upon the severability of interests clause and *Standard Oil Company of Texas v. Transport Ins. Co.*[53] and cited[54] the second "visit"[55] of the present writers to *"Who Is 'The Insured'"*. Since this was an Ohio contract, it is interesting that the district court failed to mention the recent Ohio case[56] (possibly governing but, at any rate, consistent with the result here). The district court distinguished the recent Missouri *Simpson* case[57] on the grounds (a) that *Simpson* "involves a situation wherein the employee of an omnibus insured is suing his own employer"[58] and (b) that the policy in *Simpson* "did not contain a severability clause".

Fireman's Fund v. Mosaic Tile[59]

While the employees of Mosaic were loading tile on a truck of Gate City, they injured an employee of Gate City. The injured was paid workmen's compensation and brought an action for damages against Mosaic which sought coverage under Gate City's truck policy. In a declaratory judgment action by Mosaic against the insurer covering the truck, the court of appeals held that Mosaic was not covered for the injury by its employees to the employee of the named insured, both because of the employee exclusion and because of the workmen's compensation obligations exclusion.[60] No mention was made of any Severability of Interests clause[61] and no cases were cited pertaining to either exclusion!

Transport Insurance v. Standard Oil[62]

The last (hopefully) of the new "no coverage" cases is the one which purported to follow Judge Brown. This was a declaratory judgment proceeding brought by an oil company against the automobile insurer of a truck to establish coverage for the oil company under the automobile policy for injury to the truck driver from an explosion at the loading docks of the oil company. The Court of Civil Appeals held that there was coverage for the oil company for injury to the employee of the named insured, especially because of the severability of interests provision in the automobile policy, distinguished *American Fidelity v. St. Paul-Mercury*[63] as "written without the ap-

[51]The clause was probably not included in the policy under review.

[52]*General Aviation Supply Co. v. Ins. Co. of N. A.*, 181 F. Supp. 380 (U.S.D.C.E.D. Missouri E.D. 1960), R. & A. Case No. 1969.

[53]324 S.W.2d 331 (Tex. Civ. App. 1959), R. & A. Case No. 1802. Present writers' note: This decision was later reversed, 337 S.W.2d 284 (Tex. 1959), R. & A. Case No. 1802.

[54]181 F.S. 384.

[55]Footnote 10, *supra*.

[56]*Travelers Ins. Co. v. Buckeye Union Cas. Co.*, 160 N.E.2d 874 (Ohio C.P. 1959), R. & A. Case No. 1866.

[57]*Simpson v. American Auto. Ins. Co.*, 327 S.W.2d 519 (Mo. App. St. Louis 1959), R. & A. Case No. 1877.

[58]We do not so read *Simpson;* the injured in *Simpson* was an employee of one named insured and sued an omnibus insured. The District Judge in *General Aviation* implied the hope that *Simpson* would be reversed. We express that hope. *Simpson* was wrong.

[59]*Fireman's Fund Ind. Co. v. Mosaic Tile Co.*, 115 S.E.2d 263 (Ga. 1960), R. & A. Case No. 2051.

[60]For the latter, see footnote 16, *supra*.

[61]The accident occurred November 29, 1955, so there probably was none.

[62]*Transport Ins. Co. v. Standard Oil Co. of Texas*, 337 S.W.2d 284 (Tex. 1959), reversing *Standard Oil Co. of Texas v. Transport Ins. Co.*, 324 S.W.2d 331 (Tex. Civ. App. 1959), R. & A. Case No. 1802.

[63]*American Fidelity & Casualty Co. v. St. Paul-Mercury Ind. Co.*, 248 F.2d 509 (C.A. Fifth Cir. 1957), reversing *St. Paul-Mercury Ind. Co. v. American Fidelity and Casualty Co.*, 146 F.S. 39 (U.S.D.C. M.D. Alabama N.D. 1956), R. & A. Case No. 503.

plication of the severability of interest clause", and cited[64] our second "visit".[65]

The Supreme Court reversed, holding that, notwithstanding the severability of interests clause, the "weight of authority is that if the injured party is the employee of any person who is insured under the policy, the employee exclusion is applicable although the injured may not have been an employee of the person committing the tort"[66] and, presumably, claiming coverage. The Supreme Court's opinion likewise cited[67] our second "visit"[68] but pointed out that the cases cited in that article had been "ably distinguished" by Judge Brown in *American Fidelity v. St. Paul-Mercury*.[69] The Supreme Court went on to cite the cases which it felt supported its view, cited no cases to the contrary, and, while heavily relying, for Texas, upon Judge Brown's views in *American Fidelity v. St. Paul-Mercury* (which, as may be recalled, Judge Brown expressly limited to Alabama), failed to mention Judge Brown's later decision to the contrary[70] pertaining to Louisiana.

In a dissenting opinion by the Honorable Ruel C. Walker, joined by Justices Meade F. Griffin and Robert W. Hamilton, the point was made that none of the cases cited in the majority opinion involved a policy containing the Severability of Interests clause and the dissenting opinion indicated that "there seems to be only one prior decision which is squarely in point", *General Aviation*.[71] The dissenting opinion raised the question "Why was * * * [the severability of interests clause] added to the policy?" and answered that the clause "states quite plainly that although the unqualified word 'insured' includes the named insured and may also include one or more additional insured, a mention of 'the insured' is not to be taken as a reference to all such insured persons. Instead the term is used throughout the policy to refer to a particular insured as a separate and distinct individual, apart from any and every other person who may be entitled to protection thereunder. In other words, when a claim is asserted against one who is an 'insured' under the policy, the latter is '*the* insured' for the purpose of determining the company's obligations with respect to such claim. His rights are not to be affected or impaired by the fact that another person may also be an 'insured', except that the company's liability cannot exceed the limits stipulated in the policy".[72] The dissenting opinion then went on to state that "Even prior to 1955 there was respectable authority for the proposition that the rights of each insured under the policy are to be determined as if there were no other person protected thereby, and it seems clear to me that the severability clause was added for the purpose of removing any doubt as to the intention of the parties in that respect. Under the facts of the present case, 'the insured' is * * * [the oil company]. * * * [The injured] was not employed by * * * [the oil company] * * *. In my opinion the claim does not fall within the policy exclusion * * * and I would affirm * * *".[73]

Curtain

As this drama concludes and the third (perhaps we should say the fifth and, hopefully, the last) curtain comes down, our epilogue re-"sounds":

1. A "caveat" against any mental block based on the unsound economic theory that the omnibus insured who did *not* pay the premium should not have "more coverage" than the named insured who *did* pay the premium. The theory is unsound because the coverage for the omnibus insured is not *more than*, but rather *equal to*, the coverage for the named insured, each having (so far as the employee exclusion is concerned) coverage for injury to any person except his *own* employee,
2. The fact that, for twenty years, at least, the insurance companies partici-

[64] 324 S.W.2d 335.
[65] Footnote 10, *supra*.
[66] 337 S.W.2d 288.
[67] 337 S.W.2d 289, 290.
[68] Footnote 10, *supra*. Strangely, after citing our 1955 second "visit", the Supreme Court stated, 337 S.W.2d 290, "Recently, the same authors have written what they denominate as an 'up-to-date' version of the article written in 1955". Was the court anticipating this "revisit", provoked, as it was, by this opinion?
[69] *American Fidelity & Casualty Co. v. St. Paul-Mercury Ind. Co.*, 284 F.2d 509 (C.A. Fifth Cir. 1957), reversing *St. Paul-Mercury Ind. Co. v. American Fidelity and Casualty Co.*, 146 F.S. 39 (U.S.D.C. M.D. Alabama N.D. 1956), R. & A. Case No. 503.
[70] *Stewart v. Liberty Mutual Ins. Co.*, 256 F.2d 444 (C.A. Fifth Cir. 1958), R. & A. Case No. 1603.
[71] *General Aviation Supply Co. v. Ins. Co. of N. A.*, 181 F.Supp. 380 (U.S.D.C.E.D. Missouri E.D. 1960), R. & A. Case No. 1969. The statement appears to be correct.
[72] 337 S.W.2d 291.
[73] 337 S.W.2d 291-292.

pating in the standard provisions program have intended the result for which the flag is carried here, and

3. The basic fact that, regardless of any doubt which previously existed, the underwriters have now made their intention abundantly clear by spelling out either that "The term 'the insured' is used severally and not collectively"[74] or, alternately, that "The insurance *** applies separately to each insured against whom claim is made or suit is brought ***".[75]

Epilogue

The reader will, perhaps, remember that in the preceding text, under the title *"American Fidelity v. St. Paul-Mercury"*[76], the writers chided Judge Brown for basing his 1957 views of Alabama law[77] upon non-applicable *McDowell*[78].

Judge Brown is vindicated! Alabama has now spoken, in relation to facts which *are* in point, holding that an omnibus insured under a truck policy has no coverage for injury by its employee to an employee of the trucker-named insured, in an accident arising out of the loading of the truck[79].

As in Judge Brown's case, the Alabama policy apparently contained no Severability of Interests provision.

The new result in Alabama does not, of course, change the position of the writers, but at least it causes us to, and we do, offer our apologies to Judge Brown for our underestimation of his perspicuity with regard to what the Alabama law *would be* three years later!

[74]Footnote 8, *supra.*
[75]Footnote 9, *supra.*
[76]Preceding the reference to footnote 33.
[77]Apropos because of diversity jurisdiction.
[78]Footnote 32, supra.
[79]*Michigan Mutual Liab. Co. v. Carroll,* Ala., 123 So. 2d 920 (12-8-60 advance sheet), R. & A. Case No. 2109.

The Automobile in Court

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The Problem

THE POPULATION explosion of the middle of this twentieth century has brought with it a marked increase in the number of automobiles on our highways. And a great many of these automobiles have found their way into our courts. It has been reported that a summons is issued every thirty seconds for a traffic law violation in New York City, and that in 1959 about one-third of the nation's approximately 90,000,000 motorists were cited to appear in traffic courts for quasi-criminal offenses.[1]

That, however, is only a small part of the total story. In 1959, 41.3 per cent[2] of all those killed in accidents[3] lost their lives in motor vehicle accidents.[4] Disabling injuries from motor vehicle accidents numbered about 1,400,000 in 1959, at an estimated cost of nearly six billion dollars.[5]

It is common knowledge that a very high percentage of automobile accidents resulted in claims for damages and suits thereon, although statistics show that 95 per cent of the actions brought were settled and only about 1.5 per cent of all claims of this nature have gone to judgment after trial.[6] As a result of this litigation, it has been asserted that automobile accident cases clutter up and delay the effective functioning of our judicial system.[7] Discussing the same subject, Governor Brown of California is quoted as saying that the "processes of justice are too slow and public skepticism about the inadequacy of our present court organization and administration is already widespread."[8] "The use of the automobile for every movement—to go to the corner grocery, to take the children to school, to go to business and social affairs, for vacations, for business trips, for every reason under the sun and for no reason at all"—is charged with causing an almost incredible number of personal injury and property damage suits.[9]

Court congestion and delay in the disposition of litigation have become matters of nationwide concern and have resulted in numerous studies. In May, 1956, there was convened, on the invitation of Attorney General Herbert Brownell, Jr., a Conference on Court Congestion and Delay in Litigation, composed of the presidents of the bar associations of the states and larger cities and the heads of other bar, judicial and research organizations. The executive committee of this conference promptly reported that, "Prolonged and unjustified delay is the major weakness of our judicial system today."[10]

However, it has been shown that the principal problems of court congestion and delay exist only in a few metropolitan centers, and that the blame for the conditions there existing cannot be saddled on one

[1] Zeichner, The Errant Motorist: Public Enemy No. 1, 46 A.B.A.J. 151 (1960).
[2] 37,800.
[3] 91,600.
[4] National Safety Council, Accident Facts (1960).
[5] Ibid.
[6] Gair v. Peck, 6 N.Y. 2d 97, 160 N.E. 2d 43, 46 (1959), cert. denied, 361 U.S. 374 (1960).
[7] Weigel, Preliminary Report on Plans for Inquiry Into the Wisdom of a California Automobile Accident Commission, 34 Calif. State B. J. 393, 402 (1959).
[8] 1 For the Defense 2 (1960).
[9] LaBrum, Congested Trial Calendars: It's About Time To Do Something About Them, 43 A.B.A.J. 311 (1957).
[10] The Law's Delay: Report of the Attorney General's Conference, 43 A.B.A.J. 242 (1957).

type of case—namely, automobile litigation.[11]

The problem of delay in court is not new. Governors of New York complained about it as long ago as 1828.[12] Roscoe Pound, addressing the American Bar Association Annual Meeting in 1906 on "Causes of Popular Dissatisfaction with the Administration of Justice," voiced the belief that the primary cause of such dissatisfaction, then as now, was delay.[13]

But today, in searching for a "whipping boy," numerous persons and organizations are charging that the automobile in court is the cause of most of our problems of court congestion and delay. Writers are asking whether the "negligence law of the nineteenth century," the "horse and buggy doctrines of the 1800's," can "withstand the strains of the highway and skyway of tomorrow."[14]

It cannot be denied that the mere presence of the automobile in court is an important factor in the creation of the problem with which we are now faced. However, that problem has become one of major consequence as a result of some contributing causes, to which we now turn our attention.

Some Causal Factors

We should be less than realistic if we ignored the fact that the driver of a high-powered automobile, as a mere human being, is confronted with a multiplicity of hazards and duties as he spins along our streets and highways. As Green[15] puts it, he "must observe the operation of other vehicles, front and rear and to the sides . . . must observe road signs, stop signs, cautions, traffic lines, light signals and those of traffic officers . . . must observe his speed and that of others . . . must watch for signals of other motorists and give proper signals himself . . . must know the operating mechanisms of his machine, check their operations as he travels, and maintain his rapidly moving and complex machine under control at all times."

Confronted with these and further heavy responsibilities as a motorist, the "law-abiding citizen in a moment may turn into a traffic violator almost without intending to be such and may find the step to manslaughter on the highway even shorter than he imagined."[16]

If such a driver is a stable, reasonably mature individual with an adequate control of his emotions, he may be expected to maintain those characteristics when he takes the wheel of a car.[17] If he is properly trained as a driver and abides by his training, he is likely to escape injury.[18]

Unfortunately, too many motorists do not meet those specifications, else the record of traffic law violations would not show that the traffic case load has mounted, as year by year more cars roll onto car-saturated roads.[19] To deal with this aspect of the problem, there must be more effective law enforcement and more individual self-discipline, and the motorist must come to realize that his duties as a driver include not only the safety of himself but also a great social responsibility for the safety of others who ride in and drive automobiles on the highways.

In addition, there has developed in the last decade an increased claim consciousness on the part of the American people. A general feeling has grown up that if something happens to injure a person or his property, someone else ought to pay for it, regardless of whether the injured person might have caused the damage himself. William H. Rodda, Secretary of the Transportation Insurance Rating Bureau, Chicago, speaking before an institute of the Nebraska Insurance Federation in Omaha, in October, 1959, said:

> "There is also the feeling that an accident should be made a profitable thing whenever possible. Excessive verdicts for accidents, and in some areas the activities of ambulance chasers, have contributed to this feeling that a person can make money out of any accident that occurs."[20]

The utterly unscrupulous attitude of many persons in the matter of claims for damages has been severely criticized by the

[11]Ghiardi and Morris, Can Courts, Juries and Cars Coexist, 24 Ins. Counsel J. 346, 353 (1957).

[12]Hart. Shall the Jury System be Sacrificed on the Altar of Economy, 27 N.Y. State B. Bull. 146 (1956).

[13]Burger, The Courts on Trial: A Call for Action Against Delay, 44 A.B.A.J. 738 (1958).

[14]Green, Traffic Victims, Tort Law and Insurance, 63, 68 (1958).

[15]Id. at 66-67.

[16]Chief Justice Arthur T. Vanderbilt, quoted in Zeichner, The Errant Motorist: Public Enemy No. 1, 46 A.B.A.J. 151 (1960).

[17]Id. at 152.

[18]Gene Blake, writing in the Los Angeles Times of December 13, 1959, says that one out of every two Californians now living will die or be seriously injured in a traffic accident before reaching the age of 65 years.

[19]Zeichner, The Errant Motorist: Public Enemy No. 1, 46 A.B.A.J. 151 (1960).

[20]44 Ins. L.J. (1959).

Very Rev. Francis J. Connell, of Catholic University of America, who has said:

> "When a person has suffered some real harm, he may press his claim to the genuine amount of loss he has incurred and may make use of legal measures to win his claim. But if he demands more than what he realizes was the true amount of the injury, he is just as truly a thief as a man who enters a house and steals from a safe."[21]

Despite the efforts that have been made in public education, there is an unfortunate lack of general understanding that insurance companies are fundamentally merely the administrators of the funds with which they pay claims and satisfy judgments. Those funds are derived from the premium contributions of the motorists in the jurisdiction of the court where the awards are made and it is the "home town dollar" provided by the motorist himself, not wealth from the treasury of some non-resident corporation, that foots the bill for automobile accident losses. Were this fact better understood, it probably would not have been necessary for Monsignor Connell to say:

> "Sometimes people have the idea that when an insurance company is bearing the expense, they may raise the amount beyond the sum of actual damage. Of course, this is an erroneous notion. It is just as much a sin of injustice to exact money from an insurance company by false claims as it is to victimize a private individual."[22]

Thoughtful observers have noted an apparent weakening of the moral fiber of the community as it bears on claims for personal injuries. In a recent report,[22a] a committee of prominent trial lawyers says:

> "Prosecuting authorities, even judges, ignore demonstrated instances of perjury and, as if they arose out of some kind of game, they are lightly brushed aside. There seems to be a belief, even among people of otherwise high moral principle, that the word 'honesty' has a different and more liberalized meaning in litigation involving claims for personal injuries."

Coincidental with the development of those attitudes has been the formation and growth of an organization of lawyers[23] claiming to be "dedicated to the rights of injured persons." It came into existence in 1946 and was "7500 strong" in 1959.[24] It became the advocate of "the adequate award,"[25] and then "the more adequate award."[26] It decried "gaslight verdicts in the atomic age."[27] It described its "adversaries" as "the powerful insurance associations and lobbyists, the gigantic automotive industry, the vast drug and pharmaceutical enterprises and others."[28] It gave as a reason for the increasing size of jury verdicts the fact that "the plaintiffs' bar has become better trained and educated."[29] Its editor-in-chief has spoken of it as "an unvarnished bar association of plaintiffs' lawyers,"[30] and as an "organization to comfort the afflicted and to afflict the comfortable."[31]

A past president of that organization, and one of its most prolific writers has authored a five-volume, 5018 page work expounding his views as to what the plaintiff, his counsel, his investigators, his witnesses, the judge and the jury should do in a personal injury case.[32] Dean William L. Prosser says[33] that this book tells "how to wring from an impressed and sympathetic jury every last possible nickle that can be obtained for the plaintiff, and how to build up and magnify whatever case he may have until the recovery reaches or exceeds the absolute maximum which any court can conceivably allow to stand." He notes that the author "has no interest or concern with evenhanded justice" but seeks the "maximum possible amount for the plaintiff."

In reviewing that book in 1955, Dean Prosser predicted that, as its impact spread across the country, more would be heard of

[21] The Liguorian, July, 1958.

[22] Ibid.

[22a] Report of Automobile Insurance Committee—1957, 25 Ins. Counsel J. 11, 12 (1958).

[23] National Association of Claimants' Compensation Attorneys, commonly called "NACCA."

[24] NACCA Thirteenth Annual Convention Proceedings 749 (1959).

[25] Belli, The Adequate Award, 39 Calif. L. Rev. 1 (1951).

[26] Belli, The More Adequate Award (1952), noted in 10 NACCA L.J. 342 (1952).

[27] Lambert, NACCA—Rumor and Reflection, 18 NACCA L.J. 25, 33 (1956).

[28] Ashe, NACCA—An Appraisal of Its Objectives, NACCA Thirteenth Annual Convention Proceedings 718 (1959).

[29] Lambert, NACCA—Rumor and Reflection, 18 NACCA L.J. 25, 33 (1956).

[30] Ibid.

[31] 24 Ins. Counsel J. 178 (1957).

[32] Belli, Modern Trials (1954). Volumes 4 and 5 relating to Damages were published in 1959.

[33] Calif. L. Rev. 556, 557 (1955).

proposals to abolish jury trials in personal injury suits in the United States. He spoke as a prophet. The "Hollywood Type of Trial," advocated by the NACCA writers, has emerged in state after state, and dissatisfaction with that type of court proceeding has unquestionably been an important factor in producing the spoken and written words of judges, torts professors, editors, insurance executives, and office holders in high places, who question whether we must sacrifice our heritage of trial by jury for reasons of economic necessity.[34]

Another development during the past decade relates to the medical aspects of personal injury litigation. The organized plaintiffs' lawyers consider the subjects of forensic medicine and medical-legal learning of "prime importance" in their educational program.[35] They have devoted hundreds of thousands of man hours to seminars where doctors and lawyers join in training their fellows in the art of "making the most" out of even trivial injuries. A flood of books relating to medical-legal matters and trial tactics has streamed from the presses. In their thousands of pages these books supplement the material presented in the seminars. Their publishers make a direct appeal to the profit motive, as is evidenced by advertising urging prospective readers to "cash in on negligence cases" and to "learn better ways to obtain larger verdicts in personal injury cases."

The Law-Science Academy of America and its affiliate, The Law-Science Foundation of America, under the leadership of Dr. Hubert Winston Smith, a physician-lawyer on the faculty of the University of Texas School of Law, conduct teaching programs in "medicolegal trial techniques" from coast to coast and, in the summer of 1960 presented such a program for eight weeks at Crested Butte, Montana, where registrants may vacation with their families while studying what Dr. Smith has called "the nature and consequences of trauma and injury in respect to civil and criminal litigation, and medicolegal trial technique."[36] These same organizations are establishing a law club for students who are particularly interested in preparing for trial practice and will provide "scholarships" for some such students at the Crested Butte program. While Dr. Smith has described the Law-Science Academy as "a spearhead of a social movement for the improvement of Law and the administration of Justice,"[37] his teaching program probably tends to overemphasize the medical aspects of personal injury trials, with the result that (1) some such trials are more time-consuming than would seem to be justified, (2) certain types of injuries are caused to appear more serious than they really are, and (3) the emphasis on injuries and damages tends to minimize the importance of determining that liability must exist before damages can be awarded.

Another contributing cause of our existing court congestion and delay is the apparent unwillingness of parties and their counsel to settle cases without going to court. J. Harry LaBrum,[38] in an excellent discussion of this subject, says:

> "A staggering part of our backlog in almost every court represents cases which will *never* be tried. They are bound to be settled. Many of them are cases which, with some determined effort and plain talk by an adjuster or by house counsel, would never have reached court."[39]

There is too much of the "courthouse door" complex in settlement negotiations. We are told that this is due to "human nature." If that be true, the time has come when lawyers and litigants must substitute good judgment and common sense for such human nature. Every just claim, whether it be for personal injury or property damage, should be promptly and adequately compensated, and every non-meritorious or exaggerated claim should be effectively resisted. This means that both sides should fairly, honestly and realistically evaluate a case and make a determined effort to dispose of it, if a settlement is warranted, at the earliest possible moment. Also it is necessary to make a further reduction in the number of cases presently coming to trial by using the influence of the judicial machinery to dispose of lawsuits before they reach the courtroom. Unquestionably, the increasing cost of litigation plays a substantial part in the current agitation for

[34]Ryan, Some Signs of Approaching Disaster, 1 For the Defense 1 (1960).

[35]Lambert, NACCA—Rumor and Reflection, 18 NACCA L.J. 25, 30 (1956).

[36]Smith, Law-Science Movement: Philosophy and Practice, 9 Va. L. Weekly, No. 4 (1958).

[37]Quoted from the Newsletter of the Law-Science Academy, September 15, 1959.

[38]Of the Philadelphia bar.

[39]LaBrum, Congested Trial Calendars: It's About Time To Do Something About Them, 43 A.B.A.J. 311, 312 (1957).

some plan, other than trial by jury, to dispose of automoile accident claims.[40]

Finally, in surveying these causal factors of court congestion and delay, we must recognize the following:[41]

(1) Undermanned courts.
(2) Lack of centralized court administration.
(3) Inadequate case assignment methods.
(4) Uneven distribution of judicial work.
(5) Failure to make adequate use of time-saving methods like pre-trial.
(6) Inefficient use of the time judges spend at work.
(7) Dilatory tactics of some lawyers and their tolerance by some courts.
(8) Complicated court systems.
(9) Short jury trial days.[42]
(10) Short jury terms.
(11) Prolonged vacation periods.
(12) Lack of standardized instructions and proper rules of court.
(13) Insufficient number of trial lawyers in some law offices handling a large number of negligence cases.
(14) Lack of cooperation of some counsel with the courts.

The listing of those causes of court congestion and delay readily emphasizes the fact that manpower is the basic problem. The creation of additional judgeships has been recommended on countless occasions. But the full utilization of our existing judicial manpower is as important as the creation of new judgeships. Such a rare and unique resource must not be wasted.[42a]

Likewise, better use must be made of the available trial lawyers, especially in the large metropolitan areas. It is true that much civil trial work is concentrated in a few law offices, but changes in scheduling procedures and a firm policy of avoiding last minute delays can do much to improve this situation. Also, the legal profession must train young men to take care of the legal needs of the community,[42b] and when more business becomes concentrated in one firm than it can handle, it must put on more legal help or let some of the business go to offices which have the time to handle it.[42c]

Of course, the causes of court congestion and delay mentioned above apply to all types of personal injury litigation, not merely to automobile cases. In 1959 work accidents injured 4,300,000 persons, home accidents disabled about 4,000,000 persons, and public non-motor-vehicle accidents produced about 2,000,000 disabling injuries.[43] Thus, we see that the disabling injuries (1,400,000) from automobile accidents amounted to about 12 per cent of the total. But it is likely that automobile accidents produce more lawsuits per accident than do the other types, although no reliable statistics have been found. Consequently, it is understandable that the hue and cry for reform is directed at automobile accident litigation. Let us, then, consider some of the suggested remedies.

Some Proposed Remedies

As a result of the mounting toll of losses due to bodily injuries and deaths caused by the operation of automobiles, and the court congestion and delay allegedly resulting, at least in part, therefrom, many persons have come forth with "remedial" suggestions which they hope or believe may provide solutions to the apparent problem. Financial responsibility laws exist in forty-nine states[44] and are being constantly improved. Massachusetts, North Carolina and New York have compulsory insurance statutes.[45] Legislation has been enacted in various forms to provide for unsatisfied judgment funds.[46] "Medical pay" provisions in insurance policies have been broadened, and one insurance company is writing a policy that includes a voluntary compensation plan.

Rehabilitation of injured automobile accident victims is a subject that is receiving careful study. This subject presents a problem more serious than that of rehabilita-

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[40]Cowie, The Growing Cost of Tort Litigation and Its Significance to The Public and The Profession, 26 Ins. Counsel J. 590, 592 (1959).

[41]Ghairdi and Morris, Can Courts, Juries and Cars Coexist, 25 Ins. Counsel J. 346, 351 (1957); Norris, The Law's Delays in Ohio: Remedy Without New Legislation, 33 The Ohio Bar 789 (1960).

[42]See also, Kalven, Zeisel and Buchholz, Delay in Court, chs. 15 and 16 (1959).

[42a]Johnson, Judicial Manpower Problems, 328 The Annals of The American Academy of Political and Social Science 29-36 (March, 1960).

[42b]Judge Ulysses Schwartz in Gray v. Gray, 6 Ill. App. 571, 580-81, 128 N.E. 2d 602, 606-07 (1955).

[42c]Mr. Justice Jackson in Knickerbocker Printing Corp. v. United States, 348 U.S. 875 (1954).

[43]National Safety Council, Accident Facts (1960).

[44]Loiseaux, Innocent Victims 1959, 38 Texas L. Rev. 154, 157 (1959).

[45]Ibid.

[46]North Dakota, New Jersey, Maryland and New York.

tion of persons injured at work, in which field considerable progress has been made. Many automobile accident victims could be helped substantially by having access to great rehabilitation centers such as the Kessler Institute for Rehabilitation, in West Orange, New Jersey, the Institute for the Crippled and Disabled and the Institute of Physical Medicine and Rehabilitation at New York University—Bellevue Medical Center. Establishment of similar facilities throughout the country is in process but needs to be expedited. Rehabilitation has emerged as a new and dynamic force in modern medicine and its effective utilization can do much to repair the damages suffered by automobile accident victims. An anticipated result thereof would be less litigation and fewer exorbitant verdicts.[46a]

Lately there has been a renewal of interest, in some quarters, in automobile accident compensation concepts which would compel the payment of compensation regardless of fault.[47] The only such program now in operation in the Americas is in effect in the Province of Saskatchewan, Canada.[48]

These compensation proposals are predictated upon the premise that the automobile accident is a social hazard, an inevitable result, and a by-product of motor-minded American progress.[49] One writer contends, "The use of automobiles is compulsory, not voluntary; the risk of injury is compulsory; protection by insurance should be compulsory, and without regard to fault."[50] Support for this concept stems "from the difficulty of fixing or measuring blame in most accidents and from the idea that our society should shoulder the responsibility for alleviating injury inherent in its mechanization."[51]

Under such a program every person who sustained injury would be paid according to a fixed schedule of compensation.[52] "The heedless, callous person causing injury would be paid on the identical formula as the innocent victim."[53] The careful motorist would have his defenses taken away from him and would be required to underwrite compensation for the careless and the irresponsible, to pay them for injuries that they caused to themselves.[54]

The sponsors of such suggestions seem to see nothing unrealistic in the idea of special generosity to a particular class of sufferers (automobile accident victims) while ignoring the "economic losses" resulting from injuries and deaths occurring in airplanes, on railroads, in the home, on the farm, and everywhere other than on the highways. If the matter is to be approached from the standpoint of social responsibility, it would seem that the compensation idea should include any and all forms of accidental injury and death. As shown above, in 1959, out of a total of some 11,800,000 accidental deaths and injuries, about 10,362,-200 were nonautomotive accidents, and only 1,437,800 injuries and deaths were caused by automobiles in the entire United States.[55] Should our "social responsibility" require us to provide compensation for the 10,362,-200 persons injured and killed otherwise than by automobile accidents? Should all those who have provided accident insurance and financial responsibility for themselves if an accident be the result of their fault be compelled by law to provide financial protection for persons who, injured as a result of their own negligence, have failed to provide accident-insurance for themselves?[56]

There are those who point to workmen's compensation as if it were the "father" of the automobile commission compensation

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[46a]See Fougner, Rehabilitation: Its Future Role in Third Party Claims, 27 Ins. Counsel J. 378 (1960).

[47]Since at least 1925, Robert S. Marx, of Cincinnati, Ohio has advocated such a plan. See Marx, Compulsory Compensation Insurance, 25 Col. L. Rev. 164 (1925); Marx, Compensation Insurance For Automobile Accident Victims: The Case for Compulsory Automobile Compensation Insurance, 15 Ohio St. L.J. (1954).

[48]For a discussion of this and other plans (recently proposed), see Ryan and Green, Pedestrianism: A Strange Philosophy, 42 A.B.A.J. 117, 118 (1956). See also Ehrenzweig, "Full Aid" Insurance for the Traffic Victim, Univ. of Calif. Press (1954), reviewed by Prof. Fleming James in 43 Calif. L. Rev. 559 (1955); and Green, Traffic Victims, Tort Law and Insurance (1958).

[49]Marx, Compensation Insurance for Automobile Accident Victims: The Case For Compulsory Automobile Compensation Insurance, 15 Ohio St. L.J. 134, 137 (1956).

[50]Id. at 138.

[51]Weigel, Preliminary Report on Plans for Inquiry Into the Wisdom of a California Automobile Accident Commission, 34 Calif. State B. J. 393, 403 (1959).

[52]It is sometimes suggested that payment would be denied to a motorist who is guilty of driving while drunk, or at greatly excessive speeds, or similar inexcusable, quasi-criminal or actually criminal conduct. See Weigel, supra note 51.

[53]Kramer, Fallacies of a Compensation Plan for Automobile Accident Litigation, 26 Ins. Counsel J. 420, 421 (1959).

[54]McVay, Reply to "The Case For Compulsory Automobile Compensation Insurance," 15 Ohio St. L.J. 161, 166 (1954).

[55]National Safety Council, Accident Facts, (1960).

[56]McVay, supra note 54.

concept. The two situations are not analogous, as has been frequently demonstrated.[57] In workmen's compensation the accident must arise out of and in the course of employment; the employer can and does pass on his cost of insurance or loss to his customer; there is privity of contract between the employer and claimant; preventive safety measures can be used effectively; facts can be established by an immediate investigation on the premises where the accident occurs; there is comparative equality of awards based on generally similar wage scales; the employee has a job to go back to and this, combined with the relationship of employer-employee, tends to speed recovery from disability and reduce fraudulent claims and exaggeration of injuries; workmen's compensation does not operate when the worker injures the employer.[58]

Moreover, there has been much criticism of the volume of litigation generated by workmen's compensation claims. In the states where an employee may appeal to the courts from an adverse finding by the workmen's compensation commission (of which Ohio is one)[59] there are numerous instances in which workmen's compensation appeals are contributing substantially to the congestion of the court dockets. It has been well said that the amount of court litigation in workmen's compensation represents "a great gap between theory and practice."[60] Some of this litigation turns on questions of law,[61] but many cases are appealed in order to present questions of fact to juries in trial courts.[62]

When the foregoing factors are considered in conjunction with the criticisms of inadequacy of benefits in some areas and excessively high administrative expenses in many instances, it seems apparent that an automobile commission compensation concept cannot be justified upon the theory that since workmen's compensation is "good," it would be "good" also.

The California Preliminary Report[63] recognizes that, "In order to keep the cost of universal compensation to automobile accident victims within manageable bounds, there would have to be some limits upon the amount of payments."[64] All injured persons would be paid the same for like injuries and disabilities. Sponsors of such proposals suggest that individual insurance could be carried to provide additional protection in cases where such awards would be inadequate or inequitable. Thus the skilled surgeon, who lost an arm in an automobile accident through no fault of his own, would be expected to insure his own losses over and above the amount the commission would pay, under the schedule, to any person who lost an arm, regardless of age, sex, occupation, condition of health, or degree of fault.

As to the amounts of the payments to be made by an automobile accident compensation commission, there is no agreement among the sponsors. Professor James pleads "neither for greater nor for smaller payments, but rather for a more equitable distribution of whatever we do pay."[65] He further says, "If penury must be practiced, let it fall rather on cases where need and hardship are least, by reducing or even eliminating payments on small claims."[66] He would restrict the proposed compensation to "reparation of economic loss," suggesting that "allowance for intangible items like pain and suffering (natural enough where

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[57]Ryan and Green, Pedestrianism: A Strange Philosophy, 42 A.B.A.J. 117, 119-120 (1956); Sherman, Grounds for Opposing the Automobile Accident Compensation Plan, 3 Law & Contemp. Prob. 598 (1936); Note 32 N.Y.U.L. Rev. 147 (1957); Lilly, Compulsory Automobile Insurance, Compulsory Compensation for Motor Vehicle Injuries and Motor Vehicle Financial Responsibility Laws, Ass'n of Cas. and Surety Executives, 53 (1930, as reprinted in 1932).

[58]Ryan and Green, supra note 57.

[59]Ohio Rev. Code Ann. § 4123.519 (Baldwin 1958).

[60]Reid, U.S. Bureau of Labor Standards, Bull. 172, p. 157.

[61]"The few and seemingly simple words 'arising out of and in the course of the employment' have been the fruitful (or fruitless) source of a mass of decisions turning upon nice distinctions and supported by refinements so subtle as to leave the mind of the reader in a maze of confusion." Lord Wrenbury in Herbert v. Samuel Fox & Co. (1916) 1 A.C. 405, 419, cited by Mr. Justice Murphy in Cardillo v. Liberty Mut. Ins. Co., 330 U.S. 469, 479 (1947).

[62]See, e.g., Hallworth v. Republic Steel Corp., 153 Ohio St. 349, 91 N.E. 2d 690 (1950); Drakulich v. Industrial Comm'n, 137 Ohio St. 82, 27 N.E. 2d 932 (1940); Long v. Industrial Comm'n, 106 Ohio App. 228, 149 N.E. 2d 922 (1957); McGary v. Industrial Comm'n, 104 Ohio App. 149, 146 N.E. 2d 274 (1956); Williams v. Industrial Comm'n, 95 Ohio App. 275, 119 N.E. 2d 126 (1953).

[63]Weigel, supra note 51.

[64]A frequent suggestion has been to model payments on those found in accident and health insurance policies: viz., so much for medical and hospital expense, so much for a broken leg, so much for loss of both eyes, etc. See also Green, Must We Discard Our Law of Negligence in Personal Injury Cases, 19 Ohio St. L.J. 290, 309 (1958).

[65]James, The Columbia Study of Compensation for Automobile Accidents: An Unanswered Challenge, 59 Col. L. Rev. 408, 421 (1959).

[66]Ibid.

compensation is made by a wrongdoer) may well be out of place where the bill is being footed by innocent persons."[67]

No one contends that such a proposal would result in payment of amounts approximating those which are paid under the present system when the right to be paid is established. Obviously, no compensation concept could afford to provide just and adequately awards by common law standards for all persons injured or killed in automobile accidents, regardless of fault.[68]

The amounts of payments under the Saskatchewan plan are generally deemed inadequate, at least in our more populous areas.[69] The suggested scale of payments would ordinarily be based on the "minimum needs of low-income groups,"[70] but, at best, the awards would be similar to workmen's compensation schedules as now adopted by the various states.[71]

In California, where such a concept is receiving serious study, there were about 240,000 automobile accident claims in Los Angeles County last year. Gene Blake, writing in Los Angeles *Times*,[72] makes comparative estimates resulting in the conclusion that it would require 3000 employees and 570 referees, with a budget of $22,000,000, for the operation of an automobile commission compensation program in Los Angeles County alone. Conversely, he shows that these 240,000 claims resulted in 14,500 suits, of which only 4,800 were actually processed through the courts[73] under the present jury trial system. All the rest were settled before the automobile got into court.

Even Professor James, who has written with some enthusiasm about the automobile compensation concept, admits that if such a system were more expensive to administer and would invite more malingering and fraud than does the present system, then these charges "would constitute drawbacks" to such a program.[74]

And then there are those who feel that the proper future course for the development of tort law lies in a strict rule of liability and the effective elimination of defenses that enable defendants or their insurers to avoid such liability.[75] It is difficult to understand the thinking behind such proposals in the face of the admission by one of the proponents that "liability insurance rates here are already the highest in the world even though strict liability has not been adopted."[76] It seems apparent that those who make such proposals do so without regard to the fact that, by reason of the growing cost of tort litigation and the heavy underwriting losses of the automobile insurers,[77] the very existence of private insurance is threatened.[78]

Furthermore, our law to date has developed on the theory that "strict liability" is usually justified only by the high degree of harm certain activities are likely to produce and the unusual circumstances in which such activities generally take place. One writer has suggested that the "imposition of different rules," such as the rule of strict liability, "can be justified only if the manner in which the activity is pursued is different from the manner in which the individual member of society as a whole is expected to conduct his business."[79] The doctrine of

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[67] James, Some Reflections on the Bases of Strict Liability, 18 La. L. Rev. 293, 297 (1958).

[68] Kramer, supra note 53.

[69] Weigel, supra note 51, says that "the Saskatchewan Plan is far from the equivalent of experience with an Automobile Accident Commission in a state such as our own."

Marx, note 49 supra at 141, says, "Saskatchewan is primarily a rural province. It does not have the heavy traffic to be found on the roads of Ohio." The Temple Survey notes that a careful examination of the background of the Saskatchewan program, "the physical, demographic, and geographic facts of the Saskatchewan universe, the evolution of the program itself, and an evaluation of the techniques in use in Saskatchewan, made it apparent that its parameters—social, economic and physical—are so different from those of New Jersey that no real basis for comparison existed." Economics and Business Bulletin, School of Business and Public Administration, Temple University, Vol. 12, pp. 54-56 (March, 1960).

[70] Ryan and Green, Pedestrianism: A Strange Philosophy, 42 A.B.A.J. 117, 120 (1956).

[71] For schedules showing compensation awards in the various states, see St. Clair, The case for Private Insurance of Workmen's Compensation, 27 Ins. Counsel J. 99, 112-116 (1960).

[72] Issue of December 15, 1959.

[73] Ibid.

[74] James, The Columbia Study of Compensation for Automobile Accidents: An Unanswered Challenge, 59 Col. L. Rev. 408, 419 (1959).

[75] See Harper and James, The Law of Torts (1956), reviewed by Prof. Warren A. Seavey in 66 Yale L.J. 955 (1957).

[76] James, supra note 74, at 418.

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Year	*Underwriting Loss Sustained*
1956	$109,276,660.00
1957	205,451,725.00
1958	166,528,623.00

See Lusby, The Impact on the Casualty Insurance Industry of Recent Developments in the Personal Injury Litigation Field, 27 Ins. Counsel J. 23, 31 (1960).

[78] Cowie, supra note 40, at 693.

[79] Greene, Must We Discard Our Law of Negligence in Personal Injury Cases, 19 Ohio St. L. J. 290, 299 (1958).

strict liability was certainly never intended to be applied to the operation of a modern-day service such as the family-purpose-automobile, which is not inherently dangerous[80] and which can be operated with safety whenever stable, reasonable mature drivers pay attention to and respect motor vehicle statutes and the ordinary rules of the road.

Conclusion

That the automobile in court poses some serious problems cannot be denied. Fortunately, many thinking people are gravely concerned as to the recent developments, and numerous proposals have been made for corrective measures.[81] Of course, law should never be changed lightly and "the story of law must teach us that changes are to be made by the innovations of time slowly and by degrees."[82]

In a society that offers only limited social security, the wisdom of special generosity to a particular class of sufferers seems unrealistic, particularly when a concept such as automobile commission compensation appears to take no account of the cause of the condition it seeks to remedy.

It is generally agreed that the best defense against injuries is their prevention. More effective enforcement of our traffic laws is essential. Drivers of automobiles must be brought to realize that they cannot be allowed to drive unless they drive safely. The social responsibility of the motor vehicle operator to protect his fellows from injury and death on the highways must be recognized. The first step toward the solution of our problem must be prevention.

But despite all preventive measures, accidents will continue to occur and persons will continue to be injured and killed. How, then, shall fair and reasonable compensation be made? There is no assurance that a commission compensation concept will relieve court congestion[83] and, as shown above, there is reason to believe that the cost of operating such a plan would be enormous. Furthermore, the thesis of liability without fault is antagonistic to our long standing conviction that a man's freedom of action is subject only to his obligation not to infringe any duty of care which he owes to others.[84]

It is not sound legal thinking to recommend the adoption of a proposal such as liability without fault, which is entirely foreign to our basic concepts, merely because of the type of activity pursued by some drivers of automobiles, while the rest of our society lives under different rules.[85] While it is natural that well-meaning persons will propose drastic changes in an effort to remedy the problem, it is our duty as lawyers and citizens to make sure that such changes as are made will be consistent with the ultimate best interests of all the people, and that they will preserve and maintain individual dignity and individual rights in our free society. The principle of individual responsibility for action is so firmly imbedded in our law that any change eliminating that principle would be bound to cause a chain reaction bringing about deterioration of moral standards in particulars not now predictable. Also, we submit, the doctrine of liability without fault tends to make the individual "a beneficiary of his own carelessness and his own disregard for his fellow man."[86]

An intelligent and realistic approach to change, combined with a vigorous and well conceived attack on the real causes of court congestion and delay, will solve the problem of the automobile in court. It is neither necessary nor sensible to destroy our system of jurisprudence to accomplish that result.

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[80]Elms v. Flick, 100 Ohio St. 186, 126 N.E. 66 (1919). Compare Elliott v. Harding, 107 Ohio St. 501, 140 N.E. 338, 36 A.L.R. 1128 (1923), and Williamson v. Eclipse Motor Lines, Inc., 145 Ohio St. 467, 62 N.E. 2d 339, 168 A.L.R. 1356 (1945). See also 5A Am. Jur. Automobiles and Highway Traffic, § 194 (1956).

[81]Loiseaux, supra note 44.

[82]Zane, The Story of Law.

[83]Loiseaux, supra note 44.

[84]Read v. J. Lyons & Co., [1947] A.C. 156, 171. See also Prosser, Torts, 15, 315-49 (2d ed. 1955).

[85]Compare Plant, Strict Liability of Manufacturers for Injuries Caused by Defects in Products—An Opposing View, 24 Tenn. L. Rev. 938, 948 (1957).

[86]Kramer, Fallacies of a Compensation Plan for Automobile Accident Litigation, 26 Ins. Counsel J. 420, 424 (1959).

Attorney Fees to be Charged to Insurance Clients*

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I AM indeed glad to be here and to meet with representatives of the Insurance Section of the Tennessee Bar. It is my privilege to speak with you for a few minutes on the subject of fees. This is a subject in which all of us are vitally interested. I do not pretend to speak for the insurance industry any more than any one of you can speak for all the lawyers in Tennessee. I am sure there are just as many different viewpoints among the various insurance companies as there are among the individual practicing lawyers.

My assigned subject is "Attorney Fees to be Charged to Insurance Clients." Before attempting to get specific regarding fees, I would like to discuss some of the matters facing the insurance industry, especially the casualty part of it. They are of interest to you as well as to me, since some may point the way as to what and how fee bills may be charged in the future. Whether you derive your principal income from your insurance company clients, or from representing plaintiffs, we all have a mutual interest in this subject. You depend upon us for a substantial part of your income—a substantial part of our financial welfare depends upon you.

Assuming that we here today are representative, to a small extent at least, of the insurance companies, the defense lawyers and the plaintiff's lawyers, and even perhaps some members of the judiciary, let us remember that collectively we are concerned with the orderly administration of our American tort liability system. It has been estimated that for both personal injury and property damage liability, some three and one-third billion dollars is paid each year. This is a twelve-and-a-half-million-dollars-a-day business. These figures include both the amounts covered by casualty insurance companies as well as claims against railroads and other self-insurers. In 1958 alone, casualty insurance companies incurred claims of almost two billion dollars. These are large figures and they indicate the size of the business which both you and I serve. Each of us must keep in mind, however, that these figures are of even more importance to the general public who pays the bills. Today more and more people are regarding their insurance payments as a necessary evil and not something from which they derive a benefit, such as a new automobile or a new fur coat for the wife. My grandfather said many years ago that he had carried fire insurance on his farm property for 40 years, never had a loss, and never wanted to collect anything from the insurance company. Now, that type of feeling has changed, so that today the question is not one of carrying insurance for protection in case of a catastrophe, but of carrying insurance with the primary idea in mind of collecting enough from the company to at least break even. This change in attitude is of serious import to the practicing lawyer and to the insurance industry. As a consequence, we see insurance rates skyrocketing and more

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*Given before the Insurance Attorneys Section of the Tennessee Bar Association, Gatlinburg, Tennessee, June 9, 1960.

and more resistance on the part of the public to paying those rates. Yet at the same time we see more and more pressures from the public, and through the courts, for payment of more claims, and in larger amounts.

One of our basic problems is to keep income in line with losses and expenses. You have this same problem in your law office. That basic business equation of income minus expenses leaves profit or gain, is just as true with the insurance industry as it is with you, or with any other business. Today we have inflation in the expense of doing business, as well as many factors forcing up claims losses. You are all familiar with the upward trend of jury awards, and the consequent raising of settlement values. Recent trends in allowing more cases to be decided by the jury, rather than as a matter of law, are intensifying this problem. Today the public thinks that liability insurance is accident insurance, and that everyone should be paid regardless of legal liability. Even our definition of legal liability is being enlarged.

Another area of concern affecting our services to the public is that of a claim having different values in different jurisdictions. It is difficult to explain to a layman why a case has one value in county court in one county and a different value in another county or in federal court, or even another in a different state. In the days when we emphasized the elements of personal torts committed against other individuals, these differences were minimized. Today with liability insurance becoming of more and more social significance in our society, these questons are more important. The answers affect our loss cost and expense situation, as well as your income.

Another area of attention is that of proper medical treatment and rehabilitation of the injured person, so that he may be a useful member of our community. Today the emphasis is upon the dollar payment for injuries. Too often those actions which will cause a jury to render a high verdict are not consistent with proper rehabilitation of the injured person. Likewise, the insurance companies at times put undue stress upon a dollar settlement without regard to physical recovery. In the coming years, I believe that the insurance company, the defense counsel, plaintiff's counsel and the courts, will all have to work together to put the emphasis first upon the injured person's recovery, and secondly upon the payment for damages. Any other approach is not in the best interests of the community.

Suggested solutions to these insurance problems are being advocated in many ways in different parts of the country. That is why we hear talk about compulsory auto insurance, unsatisfied claim and judgment funds, a compensation system for automobile cases, clogged court dockets with a suggested commission to substitute for our present court system in hearing auto cases, and many other variations. These are all matters of vital concern to you and to me. Each of us probably has a different idea as to the best solution. I am not here to advocate any particular change, but I do believe some changes are coming. I question whether the concept of liability insurance, as we have known it in past years, can withstand the forces increasing the number and cost of claims; for I doubt whether the auto insurance industry will be able to maintain a marketable price. Too many people want the certainty of recovery coupled with the sky as a limit on amounts; yet at the same time they want rates maintained at the level of yesterday. These are not consistent objectives and are not economically feasible. Problems arising from this situation affect all of us, and will affect us even more in the future, because some of them may even alter the way in which we will work together.

The principle of insurance is that many pay small amounts for the few unfortunates who have losses. Today the general feeling is that the insurance premium is an investment and, as in the parable of the talents in the Bible, he who does not secure a return of more than the investment is a wastrel. Add to this element of gambling for high stakes, the tendency to exaggerate claims even to the point of actual fraud in some cases, and the feeling that the sin lies not in the commission but in getting caught, and we have the economic forces which are causing present difficulties in our business.

Now let us turn our attention to legal fees. I am going to use some figures from our own Nationwide casualty company, not because I am especially proud of them, but simply because they are the best I have at hand. I believe they are typical of the industry. One main division of our claims expense is what we call outside claims expense. That is contractual expense paid to others. It includes attorneys' fees, medical examination costs, photographers' expense and a number of other items. Last year our

total outside claims expense topped $4,000,000. Legal fees made up 74 percent of this amount or more than $3,000,000. Of our total personal injury premium income, 4.7 percent was for legal fees alone. Another way to look at this is to figure the ratio of legal fees to amounts paid on personal injury lawsuits. We find that defense fees amounted to 24 percent of the amount paid in settlement of such suits.

It has been estimated that 15 percent of the money paid in settlement of personal injury claims goes to counsel representing the plaintiff. When we add the fees for defense to the fees paid by plaintiffs, we find that 12.7¢ out of each personal injury liability premium dollar goes for legal services. These figures do not include other costs for investigation or preparation for trial or for administrative expenses. They are only for legal services to the public. If we were to add to this bill all expenses pertaining to the legal process in settling claims, including the cost of maintaining the courts, we would have a staggering amount. Is there any wonder that some people are advocating changes?

What fees should be charged an insurance company client? That is the question which is of interest to you today and is of interest to me as an executive of an insurance company. I wish I could give you a firm, definite answer—one which would be satisfactory to both of us. However, it would only take me about 30 seconds to tell you what you already know; that is, that a lawyer is entitled to a fair amount of money for his services. The lawyer only has personal services to sell, and that is what the insurance company is purchasing. We are both in the market place in that respect, since you expect to be fairly compensated for your time, knowledge and skill. We expect to pay a fair fee for this service. What is fair? That is the crux of the question. We are both interested in the quality of service as well as in the amount paid for that service. I am not going to try to tell you here today how much to charge for entering an appearance in a case, or for filing a pleading, or for a day's time in court. Each of you has your own value for these particular actions and for your time. Naturally this varies from community to community and from individual to individual within that community.

We keep statistics as to the average fee per lawsuit filed. We find that this average varies generally depending upon the size of the principal city in the community. Recently we made a survey as to how fees varied by size of community, and we found that the average in rural areas was $550; in cities of medium size, slightly higher, at $578; and in large cities, $744. These figures include the expenses charged along with the fee, but by far the largest amount is for services. We usually find that the expenses incurred are higher in the larger cities. Whether or not the lawyer in the rural community received more for his services than his brother in the large city, I cannot say. I know from our own experience that it is much simpler to investigate a claim in a rural community than it is in a large city. I imagine that your experiences would indicate that the same is true, and this difference is therefore reflected in the total bill for services and expenses.

There are many variations from the average. Fee bills vary for many reasons. Probably the most important reason is the amount of time put in on a particular case. To the home office man a large fee bill should not come unexpectedly. Usually he knows what has occurred so can judge if the amount is in line with the usual standards. When an unusual bill is received it is usually because communications have broken down; that is, the claims manager does not appreciate why so much time was necessary. This may be due to inexperience on his part, or lack of good communication by local counsel. Very occasionally do we receive a bill which appears to be based on an inflated idea as to the value of the services rendered. I suggest that the lawyer should not hesitate to discuss the question of fees with his insurance company client. I am sure that the company man will welcome such discussion. Practices vary between companies as to the service they want from local counsel. Having a clear understanding of what the company wants will go far towards obtaining understanding as to the charges in a particular case.

Keeping a record as to the time spent on a case and the time in court, and computing the charge, is a fairly simple matter. If the time has been efficiently used, and I emphasize the word efficient since no one should be asked to pay for inefficient service, there will be little question about the fee bill. I believe that lawyers have the same problem as does all business in these days of inflationary costs—how to increase productivity. The problem, stated generally, is that of producing work at a lower unit

cost so as to lower the cost to the consumer. In our business we think in terms of serving more policyholders with fewer people at less total expense. In the law office the same approach would lead to handling more cases in the same amount of time, at a resulting increase of income to the lawyer, yet reducing the unit cost to the insurance company. I suggest that more of this may be possible in the areas where legal questions are generally repetitive, with only minor points to be considered in each new case.

From my standpoint, the problem regarding fees is not so much the amount in a particular case as of the waste involved. By this I mean the number of unnecessary suits being filed, as well as the trend towards suits pending in court for longer periods. This leads to a tendency in some jurisdictions almost to force defendants to make nuisance settlements in order to get cases dismissed. I believe this is another indication that more people believe that liability insurance is to pay the plaintiff rather than to protect the defendant. This situation requires the best thinking by everyone.

An area of greater difficulty is the amount of fee which refers to the results obtained in a particular case. There are several schools of thought on this question. One is that a lawyer should only compute his fee on the basis of time; the other, that if unusually good results are obtained, the lawyer should receive a portion of the so-called extra savings. It seems to me that this extra bonus idea ignores the fact that payment of the normal fee was guaranteed, regardless of the results. In addition, the hourly or per diem charges usually indicate the value of the services as agreed upon at the time of retention, so that in a sense, the lawyer only accomplished that for which he was retained. I have even heard the extreme idea mentioned that the defense lawyer's fee should operate something like the plaintiff's contingency fee. I have never been able to understand whether this would be based upon the amount of ad damnum asked by the plaintiff, or upon the lawyer's valuation of his own services. The danger in this approach, as it appears to me, is that it leads to charging what the traffic will bear without due regard to the interest of the public. This type of thinking is similar to that of the doctor or the garage man who has two scales of prices, one to the individual who is his patient or customer, and another to the insurance company if the patient had the foresight to buy insurance. In the end the people who buy the policies are paying the bills.

I do not want to leave the impression that I expect anyone rendering service to an insurance company to be altruistic in his approach, but I do think we should expect everyone to appraise properly the value of the service rendered. We in the legal profession need only refer to the oath of office which we took as officers of the court, and to the Canons of Professional Ethics, as our guideposts in regard to our conduct. My reference to the guiding principles of conduct of our legal profession does not apply solely in the areas of fees. Many of the problems connected with the growing tendency of many individuals to try to make capital out of an insurance contract, are rooted in the moral standards, or perhaps I should say lack of standards, of our society. I am glad to see many indications that as a profession we are aware of these problems. Just within the last year or so there has been increased activity by many bar associations, and by other organized groups, who are concerned with this general situation. These actions indicate that the legal profession realizes that what is good for the public is good for them. History tells us that each generation feels that it has all the unusual problems and that the past was not as difficult, and that the future will always be better. I believe that is our position today, and I have faith that through continuing action the future will be better.

In summary, let me again say that I feel sure that every insurance company wants to pay a fair fee for services rendered. This is not necessarily the lowest fee, nor is it a fee based upon any other standard than the real value of the service rendered. The members of our legal profession, whether they represent plaintiffs or defendants, have a lot in common with the insurance industry. We are all concerned with rendering the best possible service in the manner that the public wants it. Today we are in the midst of discussion of changes we believe the public wants, and how much the public is willing to pay to get what it wants. This may lead us into changes in remedies, or in changes in procedures relating to those remedies. Even the discussion of possible changes, and certainly any fundamental changes themselves, will affect all of us in the conduct of our business. I do not believe that there are any differences in attitude or approach to these problems which cannot be solved by discussion and mutual under-

standing. I believe that we as lawyers, whether we represent insurance companies on either a salary or on a fee basis, or whether we represent plaintiffs, should have a common goal in mind—that is, the best possible service to our clients and to the community.

Again, let me express my thanks for being able to be with you today and for your kind attention.

Forand Legislation and Helvering v. Davis

G. ROBERT MUCHEMORE
Omaha, Nebraska

The Legislation

THE Honorable Aime J. Forand, Democratic Congressman from Rhode Island, introduced in the 86th Congress H. R. 4700, a bill to finance hospital, surgical and nursing home care for old-age and survivors insurance beneficiaries under the Social Security Law. Funds would be provided by an increase of one-fourth percent in both the employer and employee insurance contributions or social security tax.

Although dependent children and widows receiving survivor benefits would be eligible for the aforementioned medical care benefits, the primary purpose of the bill was to finance medical care for the recipients of old-age benefits. The bill would provide a maximum of sixty days of semi-private care in a hospital and nursing home care for a period of 120 days, less the number of days of hospitalization. An individual would not be eligible for nursing home care without previous hospitalization. Payments to hospitals and nursing homes, as well as surgeon's fees, would be fixed by agreement between the government and the purveyors of those medical services.

Additional bills to finance medical care for the aged were introduced by other congressmen in both the House and the Senate. They varied in benefits provided, the use of deductibles and coinsurance and the method of financing. But as the battle lines were drawn more sharply, the most important issue became whether virtually all of the aged should become entitled to benefits regardless of need or whether only those should become entitled who could not pay for their medical care from their own resources. Traditionally in the United States we finance benefits for the needy from general revenue through federal-state assistance programs and benefits for all through payroll taxes and the wholly federal OASI program, and this difference became part of the basic issue.

The Forand Bill embodied the concept of benefits for all and the OASI payroll tax approach. The benefits only for the needy and the assistance—general revenue approach—were embodied in H. R. 12580 introduced by Congressman Mills, Chairman of the House Ways and Means Committee. The latter bill ultimately was enacted by the 86th Congress, but the issue is far from resolved. Proponents of the OASI approach promise to again seek enactment of their bill in the 87th Congress.

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ABA Policy

The House of Delegates of the American Bar Association in August of 1959 accepted and approved a report of the Association's Standing Committee on Unemployment and Social Security recommending "(1) that the American Bar Association go on record as opposing the Forand Bill (H. R. 4700) and substantially similar legislation, and (2) that this action be communicated at the proper time and in the appropriate way to the appropriate committees of the Congress."

On August 31, 1960, the American Bar Association by action of its House of Delegates adopted the following policy statement on the subject of medical care for the aged.

I. That the American Bar Association continue to oppose legislation substantially similar to the Forand Bill (H. R. 4700—86th Congress) as recommended by the Standing Committee on Unemployment and Social Security.

II. That the policy of the American Bar Association on alternatives to Forand-type legislation be determined by the following principles.

1. The medical care of the aged can be adequately provided through voluntary insurance and prepayment plans supplemented by old-age assistance and existing state, county, and municipal programs, with timely and appropriate modifications.
2. If, because the present promise of voluntary plans is not fulfilled, or because of other compelling reasons a new government program becomes imperative, a joint federal-state program would be preferable to a federal program.
3. If a new government program of medical care of the aged is initiated, a program more closely resembling grants in aid for old-age assistance would be preferable to an extension of old-age and survivors insurance.
4. It would be desirable to include in any government program of medical care for the aged that becomes imperative provision for "contracting out" or administration through such prepayment and insurance organizations as Blue Cross-Blue Shield, group practice plans, and private insurance companies.
5. It would be desirable to make any government program of medical care for the aged that becomes imperative optional rather than compulsory for the aged individual.

This places the American Bar Association in support of benefits for the needy or the assistance approach and opposed to the OASI payroll tax approach.

Helvering v. Davis

Prior to 1935 there had been several cases holding that a state or local government could not provide old-age pensions without regard to need, although a few states were administering such laws whose validity had never been challenged. While the support of paupers had long been an accepted exercise of valid authority under the police power, the authority of the state to pay money to one who was not in need and who had rendered it no services was clearly established only shortly before the enactment of the federal social security laws. 100 A.L.R. 697, 106 A.L.R. 243, 108 A.L.R. 613, 109 A.L.R. 697.

The constitutionality of old-age benefits as part of social security was first established in 1937 in the case of *Helvering v. Davis*, 301 U.S. 619, 81 L.Ed. 1307, 57 S.Ct. 904, 109 A.L.R. 1319. In that case the court held that money spent by Congress in providing old-age benefits (there were no survivor's benefits at that time) was spent in aid of the "general welfare" and, therefore, within the authority of Congress as set forth in Article I of Section 8 of the Constitution. In support the court cited the cases of *U. S. v. Butler*, 297 U.S. 1, 80 L.Ed. 477, 56 S.Ct. 312, 102 A.L.R. 914, and *Steward Machine Company v. Davis*, 301 U.S. 548, 81 L.Ed. 1279, 57 S.Ct. 883, 109 A.L.R. 1293.

The *Butler* case held that Congress could tax and appropriate in aid of the general welfare but that the Agricultural Adjustment Act of 1933 was unconstitutional because it attempted to regulate and to control agricultural production, a matter within the reserved rights of the states and beyond the powers delegated to the federal government. The *Steward Machine Company* case held the federal-state unemployment compensation program of the Social Security Act constitutional—in part because the states were not required to enact unemployment compensation statutes—and was handed down the same day as the case of *Helvering v. Davis*.

The court in *Helvering v. Davis* first established the proposition that Congress is permitted wide discretion in determining what will contribute to the general welfare. It said: "When such a contention comes here, we naturally require a showing that by no reasonable possibility can the challenged legislation fall within the wide range of discretion permitted to the Congress . . . . Nor is the concept of the general welfare static. Needs that were narrow or parochial a century ago may be interwoven in our day with the well-being of the nation. What is *critical* or *urgent* changes with the times." (Italics added)

In determining that "the award of old-age benefits would be conducive to the general welfare," the court said in part: "Spreading from state to state, unemployment is an ill not particular but general, which may be checked, if Congress so determines, by the resources of the nation . . . . But the ill is all one, or at least not greatly different whether men are thrown out of

work because there is no longer work to do or because the disabilities of age make them incapable of doing it. Rescue becomes necessary irrespective of the cause."

The court relied heavily upon the then condition of the economy in supporting its holding of constitutionality. The Social Security Act was enacted August 14, 1935. *Helvering v. Davis* was decided in May, 1937. The above excerpts from the language of the court remind us of those critical days. Almost eight years after the 1929 stock market crash, the nation still had not found a way out of the big depression. Unemployment was a problem for many, but especially for the aged. As the court said: "The evidence is impressive that among industrial workers the younger men and women are preferred over the older. In time of retrenchment the older are commonly the first to go, and even if retained, their wages are likely to be lowered. The plight of men and women at so low an age as 40 is hard, almost hopeless, when they are driven to seek for re-employment . . . . With the loss of savings inevitable over periods of idleness, the fate of workers over 65, when thrown out of work, is little less than desperate . . . .

"The problem is plainly national in area and dimensions. Moreover, laws of the separate states cannot deal with it effectively. Congress at least had a basis for that belief."

Thus with Justices McReynolds and Butler dissenting, the court held that the provision for old-age benefits in the Social Security Act was constitutional. It seems apparent that the economic plight of the country and the then size of the problem of support of the aged and the unemployed were significant factors in the court's holding. Emphasis was placed upon the *critical* and *urgent* character of the *needs,* the fact that they were *national* in scope and that they *were not being met* in any other way.

This being so, we can justify an inquiry into the urgency and scope of the problem of financing medical care for the aged and the progress being made in its solution as factors in the authority of *Helvering v. Davis* relative to legislation of the Forand type. It is hoped that the economists will not resent a lawyer advancing the proposition that whatever the present shortcomings of the economy may be, it is not in a plight comparable to 1937. Also perhaps the actuaries and statisticians will permit us a recital of the following figures relative to the medical care of the aged.

Individuals

The problem of financing the medical care of the aged can be analyzed with regard to the number of people involved. Of the approximately 16 million individuals over 65, some 49 percent or 8 million are protected by such voluntary medical plans as Blue Cross-Blue Shield, insurance, self-insurance or group practice.[1] Another ten percent or one and one-half million fall in special groups such as veterans, medical practitioners and religious sects and orders that either do not want or do not need insurance or prepayment protection.[2] Another 16 percent or two and one-half million are receiving old-age assistance and are eligible for the medical care benefits thereunder.[3] Unfortunately, there seem to be no reliable figures on the number of aged who are receiving medical care from local charities or governmental units outside of the federal-state assistance program. Nevertheless, something like 25 percent or four million aged remain, and some of these either might obtain old-age assistance if needed or might be in such a financial position that they can pay their medical expenses from their own resources.

On the basis of the remarkable recent growth of voluntary plans, this picture can be projected into 1965. By that time it is estimated that those over 65 will total approximately 18 million.[4] Of this number between 55 and 60 percent or at least 10 million will be protected by voluntary medical care plans.[5] Another 10 percent or more, perhaps two million, should fall in the special groups that either do not need or do not want insurance or prepayment protection. At least 15 percent or 2.7 million should be receiving old-age assistance. This leaves less than 19 percent or three and one-half million, and any of these who cannot pay their medical expenses from their own resources should qualify for benefits under H. R. 12580 of the 86th Congress.

Dollars

Looking at the dollar amounts involved, one cannot be quite as precise. The total

[1]Report to Committee on Ways and Means by Secretary of Health, Education and Welfare dated 4-3-59, p. 42 and current estimates of Health Insurance Association of America.

[2]Based on U. S. Census figures.

[3]Report to Committee on Ways and Means by Secretary of Health, Education and Welfare dated 4-3-59, p. 8.

[4]Ibid p. 5.

[5]Ibid p. 91.

medical expenses of all the aged probably are between two and one-half and three billion dollars per year.[6] Of this amount various levels of government either directly or through tax credits are paying approximately 900 million dollars.[7] This includes federal-state assistance, government care for certain classes of the aged such as veterans, care provided by state, county and city hospitals and income tax deductions for medical expenses. The medical care provisions of the federal-state assistance program were liberalized in 1958, and the above figures are not sufficiently recent to reflect these liberalizations. Furthermore, disbursements under H. R. 12580 will substantially increase this amount in the future.

Further, between 500 and 600 million dollars probably is being paid annually by voluntary insurance and prepayment plans to defray these medical expenses.[8] Such plans include Blue Cross-Blue Shield, individual and group insurance policies and group practice organizations such as the Health Insurance Plan of Greater New York and the Kaiser Health Foundation on the West Coast, popularly known as "Permanente."

That should leave approximately one half of the total to be paid by the aged individually. Since the insured and prepayment plans generally cover the larger bills that occur relatively infrequently, this remaining amount should be, to some extent, made up of the small bills incurred by many people that could not be insured economically, either by private organizations or the government, and seldom constitute a great burden upon any one individual. (Forty-eight percent of aged couples incur medical expenses of less than $200 annually.)[9] Furthermore, insured and prepayment coverages generally leave a balance to be paid by the individual, and this would account for still more of this remainder.

Looking to the future, the picture improves further. The 1958 amendments to the assistance program and H. R. 12580—1960—make available to the states substantial additional federal funds for financing the medical care of the aged. Furthermore, an analysis of voluntary insurance and prepayment plans develops sound reasons for their rapid future growth—close to a 50 percent increase by 1965.[10] Thus the portion of the medical expenses of the aged paid by government and voluntary plans combined could easily increase to between 70 percent and 80 percent within the next few years.

Voluntary Plans

Thus there seem to be at least three significant factors to be considered in determining whether the case of *Helvering v. Davis* is an adequate precedent for the constitutionality of Forand legislation. The first is that in 1937 the economy was sick, whereas today it is comparatively robust. That alone reduces the size and critical nature of the problem. The second is that state and local facilities for the medical care of the aged, aided by recent and generous transfusions of federal funds through the assistance program, have grown with the problem and are making a significant contribution to its solution. Third, and perhaps most distinguishing of all, is the promise that voluntary plans will be extended to the point where they could make a much greater contribution to the solution of the problem of financing medical care for the aged. Private enterprise could offer no comparable hope for the support of the aged—and the unemployed—in 1937.

Proponent of Forand legislation have dismissed these voluntary plans as (1) covering too few people, (2) providing too limited benefits and (3) costing too much. Perhaps a critical look at these claims will help measure the confidence that should be placed in these plans.

Historically, the insuring or prepayment of medical expenses generally is about the age of the case of *Helvering v. Davis.* A small amount of individual insurance and Blue Cross protection at that time have grown into provisions today for medical care protection for over 128 million Americans—in a period of only a little over twenty years.[11]

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[6]Based upon Report to Committee on Ways and Means by Secretary of Health, Education and Welfare (pp. 24 and 25) and Source Book of Health Insurance Data, 1959 p. 44.

[7]Testimony presented before Subcommittee on Problems of the Aged and Aging of the Senate Committee on Labor and Public Welfare, June 16, 17 and 18, 1959.

[8]Based upon "Voluntary Health Insurance and the Senior Citizen," a report by New York Insurance Department (1958) p. 93, Source Book of Health Insurance Data—1959, p. 37, and the annual survey of the Health Insurance Council.

[9]Report to Committee on Ways and Means by Secretary of Health, Education and Welfare dated 4-3-59, p. 24.

[10]Ibid—pp. 90 and 91.

[11]The Extent of Voluntary Health Insurance Coverage as of 12-31-59, published by Health Insurance Council.

Extending such protection to the aged is an even more recent development. Ten years ago it was known that more medical care was required at the older ages, but experience for computing costs was very limited. By 1952 a beginning had been made by providing approximately three million aged with protection. By 1957 that figure had grown to six million and by 1960 to almost eight million.[12] On such a record a claim of present or future failure seems a bit premature. Predictions of protection for ten million by 1965 and twelve and one-half million (or 68 percent of the aged) by 1970 cannot be lightly dismissed. So much for the number covered.

As to the benefits there unquestionably have been and are cases in which they have been inadequate. But equally unquestionably, benefits are becoming more adequate. This question is closely related to that of cost, and they can be discussed together in the following paragraphs. However, it can be pointed out here that the Forand legislation would provide no benefits (with minor exceptions) when medical expenses are incurred outside of a hospital or nursing home or by one who is not eligible for OASI benefits.

Now as to cost—and more adequate benefits. This goes to the very heart of the health insurance and prepayment business and admittedly is a man-sized problem for that segment of the population whose needs are the greatest and whose resources to pay for those needs are limited. Nevertheless, it is the opinion of many that private enterprise is doing and can do the job of protecting the aged against the expenses of medical care. Perhaps the best evidence that can be introduced in support of that opinion is a description of the armory of weapons now available to attack the problem.

1. The Blue Cross-Blue Shield organizations have their so-called community rate. This permits medical care benefits for the aged at a rate that varies little if any from the rates for others. The additional cost is absorbed by a slightly higher rate for everyone in the community.
2. The insurance companies have developed special group insurance methods to provide adequate benefits for the aged at moderate cost. A group insurance rate for all may provide funding, or partial funding, for medical care coverage for retired employees. With even partial funding, usually combined with an employer contribution, the cost to the retired employee can be kept low. Or if there is no funding the retired employee can be continued as a member of the group at no increase in rate. Here the increased cost is absorbed in the general experience of the group. Finally, an admittedly less satisfactory solution is conversion to an individual policy upon retirement.
3. Individual insurance policies have attacked the problem of insuring the aged from two angles. On the one hand, policies have been offered on a wholesale or group approach with commissions and expenses kept to a minimum. On the other hand, the policies issued at the younger ages are being revised to raise or eliminate the age at which they expire. These policies may now be purchased on a level premium lifetime basis very similar to life insurance.
4. The group practice plans such as the Health Insurance Plan of Greater New York (HIP) and the Kaiser Foundation Health Plan on the West Coast (Permanente) have adopted one or more of the above methods of financing in order to provide membership for older people at rates that are equal to or compare favorably with the rates charged the younger ages.

Wisdom or Unwisdom

In *Helvering v. Davis* the court said: "Whether wisdom or unwisdom resides in the scheme of benefits set forth in Title II is not for us to say. The answer to such inquiries must come from Congress, not the courts." But since, insofar as Forand legislation is concerned, the answer has not come from Congress, some comments on the wisdom or unwisdom of such legislation may be justified. Let us dismiss for the moment our concern over whether the problem of medical care for the aged is critical or pressing or national in scope or devoid of other solutions and concern ourselves with the wisdom or unwisdom of Forand legislation as a solution of that problem.

This legislation appeals to a great many

[12]Report to Committee on Ways and Means by Secretary of Health, Education and Welfare, dated 4-3-59, p. 91 and current estimates of Health Insurance Association of America.

people. To the humanitarian it would bring medical care to a segment of those most in need of it and least able to pay for it. To many technicians it would provide a simple solution to what is perhaps the most difficult problem in the entire field of voluntary medical care protection. The solution would be tidy, relatively comprehensive and would make use of machinery and bureaucracy already in existence. To the aged it would bring "free" medical care. And no matter how administered, it would be unlikely to take any substantial amount of profitable business away from doctors, hospitals, nursing homes or the insurance companies. In fact, for all but the last, it would be likely to provide more income. Then why all the controversy?

The basic answer of most opponents of this legislation would be the simple statement: "Once legislation of the Forand type is enacted by Congress, the battle against socialization of the practice of medicine in this country will have been lost." Some of the evidence in support of this opinion, which may be startling to some, can be summarized as follows.

Expanding Social Security

The Social Security Act became law on August 14, 1935. As originally enacted, it provided in general for the federal-state categorical assistance programs of aid to the aged, the blind and dependent children, for the federal-state unemployment compensation program and for old-age benefits. The last named were limited to retirement benefits for wage earners only and were scheduled to begin on January 1, 1942. Well before that date arrived, the social security amendments of 1939 greatly enlarged the old-age benefits portion of the Act. For the benefit of those who did not live to 65 to receive old-age benefits, the 1939 amendments provided benefits for their surviving dependents. Thus the equivalent of substantial amounts of life insurance were added to the original annuity benefits. Also for those who lived beyond 65, additional benefits were provided for wives and dependent children.

Again in 1950 the old-age benefit portion of the Social Security Act was extensively amended. In addition to substantial increases in benefits, some 10 million additional individuals were made subject to the act. Although some of these consisted of new categories of the employed, the great majority were self-employed who had been excluded previously. Coverage was further extended in 1954 and 1956, benefits have been increased every two years since 1950, and during the period from 1954 to 1958, the total and permanent disability benefit provisions of the act were incorporated. The development of these provisions provides an excellent parallel for what may be anticipated if medical care provisions are added to the program.

In 1954 after prolonged efforts and against strenuous opposition, the proponents of the disability extension were successful in having enacted by a margin of a single vote what has become known as the disability freeze. This provided a benefit comparable to the waiver of premium benefit for disability under a policy of life or endowment insurance. Since 1954 the period during which an individual suffered a total and permanent disability, and therefore would pay no payroll tax or contribution, can be disregarded in computing his old-age benefits. Just two years later, in 1956, this benefit was enlarged to provide cash benefits under certain qualifying conditions to those over 50 who became totally and permanently disabled. No benefits were provided in 1956 for dependents of those disabled, but in 1958 that extension was enacted. And in 1960 Congress eliminated the age 50 requirement and provided total and permanent disability benefits at any age, subject to the requirement that the individual be fully insured.

Thus in a period of twenty-five years this country has seen this portion of the Social Security Act grow from a program that provided only retirement benefits to wage earners to a program that provides retirement benefits to both the employed and the self-employed and their dependents, survivorship benefits to dependents of the employed and self-employed, and benefits to the disabled employed and self-employed and their dependents. The tax to support this program began at 1 percent each in 1937 for both employer and employee and has grown to three percent each in 1960. The present law provides for an increase to four and one-half percent each by 1969.

After Forand

In the light of this history, what can be expected if Congress provides hospital, nursing home and surgical benefits for recipients of old-age benefits as set forth in the Forand Bill? Is there any possibility

that the program will stop there, or that continual extensions and liberalizations can be avoided?

The extension of benefits to such out-of-hospital expenses as doctors' calls, drugs and nursing services would almost certainly be demanded and would be difficult to oppose once the principle of medical care benefits as part of old-age benefits has been established. Once a more or less comprehensive program has been provided for those over 65, there would be pressure for its extension to those under 65. As many people see it, this inevitably would result in socialized medicine for all.

Much has been written concerning the advantages and disadvantages of socialized medicine. The reports received from Canada, England and other countries concerning their experience with various forms of socialized medicine are conflicting and inconclusive and may be of doubtful application to the different conditions that exist in these United States. However, there is evidence that the quality of medical care has suffered under these foreign programs and that costs have become excessive and unmanageable.

The choice is for the American people to make, but that choice should be free, open and informed. Legislation of the Forand type cannot be accepted as merely limited financial help for the aged in payment of their hospital, nursing home and surgical expenses. It must be accepted, if at all, as the beginning of an inexorable and rapid progression to the socialization of the practice of medicine with all the radical changes in traditional concepts that involves. One more of the responsibilities of state and local governments will have been surrendered to our ever growing federal bureaucracy.

Humpty Dumpty

H. C. FOSTER, JR.
Utica, New York

THE meaning of many of the words or phrases used in casualty insurance policies is becoming an increasingly significant problem, not only to those directly engaged in the business but also to defense attorneys for the companies and to those who act as independent adjusters. The problem has little, if anything, to do with the defense of a policyholder against allegations of negligence from which an accident is alleged to have resulted. On the contrary, the problem is confined almost exclusively to disputes between a policyholder and his insurance carrier or to disputes between two insurance carriers, as to the precise meaning of various words and phrases used in casualty policies.

As a research underwriter with many years of experience in the development and promulgation of casualty insurance policies, I have been asked to make some comments as to the reasons why difficulties are encountered in understanding and interpreting the words and phrases used in these policies and to make a few suggestions which will shed some light on the problem.

I envy a certain literary acquaintance of mine. He is a prominent character in the famous children's classic "Alice in Wonderland". His name is Humpty Dumpty and I should like to quote him. "When I use a word, it means just what I choose it to mean—nothing more nor less." Oh, that such a rule could be invoked by those of us who, after Herculean labors, bring forth those esoteric documents familiarly known as liability insurance policies.

Just who suffers these Herculean labors? Are they suffered solely by the members of the Joint Forms Committee charged with the responsibility of promulgating these policies? No. There is another distinct group involved, composed of the members of the rating committees of the National Bureau of Casualty Underwriters and the Mutual Insurance Rating Bureau who must first set the project in motion. The rating committees are composed *wholly of underwriters* and it is their function, by virtue of the insurance rating laws of the several states, to decide, with respect to any casualty policy or revision thereof, the desired area of coverage.

HARRY C. FOSTER, JR. *was born in New York City on March 8, 1897. He entered Union College in Schenectady, New York in September 1916. He enlisted in the Army in June, 1917 and served overseas in France and Germany with the 6th Division. He re-entered Union College in September, 1919 as of the Class of 1922.*

After some football coaching at his Alma Mater, Mr. Foster was engaged in the automobile finance business for some years. He joined the Utica Mutual Insurance Company in Utica, N. Y. in January, 1940. Mr. Foster sits on the Automobile and General Liability Rating Committees and the Governing Committee of the Mutual Insurance Rating Bureau, the New York Workmen's Compensation Rating Committee and the Joint Forms Committee, the latter committee drafting the various casualty policies in accordance with the underwriters' desires.

The eventual agreement between these underwriting committees as to the extent of coverage is then sent to the Joint Forms Committee as an expression of *intent* of the underwriters, to be translated into appropriate policy language so as to carry out that *intent*.

Please note the use of the word *intent* in the previous paragraph. It is most important. I consider it the crucial word in this article.

To digress for a moment, but only apparently. The English language is as highly developed as any written language used around the globe today. It is replete with synonyms, and antonyms for that matter, for nouns, adjectives and adverbs. It lends itself readily to the writing of outstanding prose, drama and poetry. But we are *not* writing prose, drama or poetry; we are writing, unilaterally, hopefully definitive contractual agreements to be entered into between the casualty insurance carriers and strangers. Oh, to have the power of Humpty Dumpty—the relief afforded insureds, insurers, adjusters, attorneys, judges and juries would indeed be a Godsend.

In drafting policies the *intent* of the underwriters should be expressed in language as precise and definitive as possible without indulging in excess verbiage. But this demands *brevity* which in turn requires the use of synonyms or antonyms in any explanatory discussion of the *meaning* and *intent* of the original word or words in dispute.

It seems to me, however, that the use of the first synonym (the positive approach) or the first antonym (the negative approach) necessitates the use of yet another synonym or antonym and this process may easily continue until, eventually, we come back to full-cycle to the original word which started the whole process. For example, the best definitive explanation I can give for the meaning of the word "occasional" often used in our policies, is that it is an event that is "not frequent". But this in turn demands a definition of "frequent" which again in turn demands the use of further synonyms or antonyms (remember brevity —no long paragraphs of explanation, please) until we come full-cycle to the original word in dispute. This suggests the labors of Sisyphus.

We can not seek recourse by resorting to the use of one exact written language available to us, viz., the language of mathematics because the language of mathematics deals only with size or quantity. Nor can we utilize the one nearly exact language which, centuries ago, might well have been used, viz., Latin, because Latin today is not the *lingua popularis* of any portion of the inhabited globe and its actual use today is, fortunately or unfortunately, confined to miniscule and esoteric groups.

So, we are stuck with English—a beautiful language but greatly deficient in declensions and conjugations (the glory of Latin by the way), nor do we even have masculine, feminine or neuter articles as witness, for example, the German.

What shall you do? Synonyms and antonyms all have delicate shades of meaning. It is suggested therefore that you use in your discussion or argument, those synonyms or antonyms whose delicate shades of meaning do not take you too far afield from the original word in dispute. To do this however means, in my opinion, that it is incumbent upon you to discover the *intent* (there's that word again) of the underwriters. In this way, you will be in a better position at least to choose those precise synonyms and antonyms which more adequately support your position and the "reasonable man" of the courts then may well be more prone to ally himself with you. As an aside, I admit that in some opinions the "reasonable man" seems to be somewhat "unreasonable"—a hazard of your profession.

The *intent* of the underwriters should be made known to you by company employees, articles in the insurance press, addresses at various meetings or conventions and in other ways which will occur to you. It is even suggested that the law reviews of the several schools of law will be of assistance and, incidentally, I suggest submission of papers to such a forum will be of great value on interesting cases within your purview involving policy language—not defenses against negligence per se.

I might suggest, as an interesting piece of homework, a study of *McLouth Steel Corp. v. Mesta Machine Co.*, 116 F Supp. 689 affirmed 214 F. 2d 608 (1954), which was a case decided in the final analysis solely on the meaning of words (negligence was admitted). Briefly, it involves the exclusion in all casualty policies denying coverage for damage to property "in the care, custody or control of the insured". The independent contractor hired by Mesta Machine Co. to transport and erect a gigantic steel press or something akin at the premises of McLouth Steel Corp. was unfortunate enough to have a guy rope break during the erection, as a consequence of which the steel press which he was erecting toppled to the ground resulting in considerable damage to the machine itself. The insurance carrier of the independent contractor denied coverage for the claim because the machine was property in his "care, custody or control". This is not so, said the courts, in an action brought by the contractor against the insurance company: the contractor did not have "legal or constructive" control at the time of the accident but only "possessory" control.

Immediately following this decision we, the underwriters requested clarification and reinforcement of the "care, custody or control" exclusion and the following words were added in the exclusion, viz., ". . . or property *as to which the insured for any purpose is exercising physical control*". It was felt that these additional words would serve to clarify the original intent of the underwriters as expressed in the original words "care, custody or control".

I shall conclude this article by taking a rather categorical position: primarily our

policies are drafted for the courts and not the laymen, that is to say, not the policyholders. This dictum was stated by the late John P. Faude of the Aetna Casualty and Surety Company who was and still is considered without superior in the drafting of casualty policy language. The dictum makes sense. In the defense against alleged negligence, policy language in itself is rarely, if ever invoked. Such language only comes into play as the *gravamen* of the case in actions between insurance carriers or policyholders and their respective insurance carriers. Hence the necessity, as I see it, of some knowledge of the *intent* of the underwriters and the use therefor of as precise synonyms in your argument as your vocabulary will provide.

Problems of Indemnity for Workers Injured by Radiation*

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IN spite of very extensive and widespread utilization of radioactivity for many years there has been an amazingly small number of injuries produced. This is because of the fact that those engaged in this work have taken extraordinary precautions to provide for the health and safety of potentially exposed personnel. A primary effort always has been and must continue to be directed toward the prevention of injury. However, in the event injury does occur the means must be available to provide for medical care, compensation and rehabilitation for those who are injured. A considerable amount of thought and effort has been put into the problem of indemnification for liability loss which theoretically could occur from major accidents involving large-scale nuclear installations. Attempts to provide financial protection in this area in the United States have been directed, first, through the insurance industry and the pooling of its resources and, second, through government indemnity for losses which might occur beyond the capacity of the pools, or in certain special cases beyond artificially established required limits of coverage. For several years this has been considered the most pressing problem in the indemnification field.

In the United States it has been felt by some that the present compensation system, while varying in many respects from state to state, provides a sound basis for indemnifying workers who may be injured during the course of their employment. There are others in this country who feel that the present methods of dealing with the problem are already inadequate and that a complete re-evaluation of the system is necessary. During March 10-19, 1959, a series of hearings were held before the Sub-Committee on Research and Development of the Joint Committee on Atomic Energy of the Congress of the United States on the subject "Employee Radiation Hazards and Workmen's Compensation". A considerable amount of evidence was presented at these hearings both on the potential hazards and radiation protection as well as opinions of various segments of American industry, labor and government relative to the broad problem of radiation injury and the means of providing financial protection in the event of such injury. It is notable that throughout these hearings it was readily admitted by nearly all witnesses that the record established to date has been excellent, but that there are many potential problems which could arise in the future which should be given consideration before they become serious. It is the purpose of this discussion to explore many of these problems and to attempt to focus attention on the most difficult ones in the hope that adequate solutions will be found.

In the United States the existing concept of workmen's compensation is to utilize wage loss as a basis of payment and to limit such payments to the injured employee and his immediate dependents. As will be seen in subsequent discussion, this apparently fails to meet some issues which have been raised, but there may be some doubt as to whether or not these issues can be met by any reasonable compensation system. In other words, to go beyond the basic concept in the light of present knowledge is to invite endless litigation or to cause the establishment of arbitrary or capricious rules,

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neither of which can provide an equitable means of dealing with the problem.

If one agrees that the purposes of any compensation system are to provide for adequate financial protection of injured workers or their families; weekly benefits in place of lost wages; adequate medical and hospital care; and rehabilitation of the seriously injured, then it should be possible to include radiation injury within the framework of our existing compensation system in the United States and to adhere to its established purpose.

Kinds of Exposures

In reviewing the overall problem it will be helpful to examine briefly the kinds of exposures to which industrial workers may be subjected and the possible consequences of such exposures. Employees in industry, educational institutions, medical institutions, as well as large nuclear energy operations, make up the vast majority of those potentially exposed to excessive radiation. In hospitals and clinics as well as doctors' and dentists' offices the technicians who operate the equipment, as well as the physicians directly involved, may be exposed to radiation from such devices as x-ray machines, betatrons and also from various kinds of isotope application, including both external and internal sources. In industry we are finding wide application of isotopes not only in research laboratories, but also in industrial processes. In educational institutions we also find radiation-producing devices as well as radioactive isotopes. Here the employees exposed consist largely of members of faculties and maintenance personnel. In this case students are considered as members of the general public and they are not involved in the compensation problem. The highest levels of exposure are to be found in large nuclear energy installations, including fuel fabrication plants, reactors, fuel reprocessing installations and among users of extremely large radiation sources. In addition to these, one may find radiation exposures from incidental sources such as electronic power tubes in industry.

In addition to exposures which all individuals referred to above may receive at their work, there are at least three other sources of radiation over which they have no control to which they may be subjected. One of these is the fallout from nuclear detonations which they share with the rest of the general population. A second source of exposure of some consequence is that which may be received as a result of medical diagnosis or treatment. Finally, the entire world's population is exposed to what is known as background radiation which results from natural radioactive materials occurring in the soil, water and air of man's environment. If evidence of non industrial exposures is not available in an employee's record, industry could well be placed in the position of having to provide indemnity payments for radiation injury which it did not in fact produce.

Possible Consequences of Over-Exposure

The most significant consideration is the consequences which may result from over-exposures to radiation of various kinds. The first and most obvious is immediate injury, such as radiation burns resulting from very large single over-exposures such as might occur in the event of an accident in an industrial plant, hospital or nuclear installation. The extent of the acute injury will be obvious within a matter of hours or days and this phase of the problem will be relatively simple from a compensation standpoint. An accident occurred—an individual was obviously injured. It is not so simple, however, to predict what the long-term consequences of such an accident may be in any individual. It is at this point that we find our first problem with many existing compensation laws.

A second group of effects produced by radiation includes those which result from long-time exposure to low levels of either external or internal radiation and result in some chronic disability such as leukemia, cancer or cataract. As in the case of the acute injury, the damage which has occurred results in a disability to the affected worker. The problems in the compensation field here arise from the delay in the onset of the disease and the difficulty of establishing the date of injury. This, however, is not limited to radiation. We have seen such delayed responses in other occupational diseases, notably beryllium poisoning.

There has been a considerable amount of publicity given to several fairly nebulous effects of radiation which can be demonstrated in animals or insects on a statistical basis, but certainly cannot, at the present time, be applied quantitatively to humans, individually or collectively. These include such things as shortening of the life span. There is absolutely no known way, particu-

larly in an individual in apparent good health, of predicting the possible effects many years in the future of a low level exposure or series of low level exposures to radiation. Since there is no evidence of any kind of injury, there can hardly be any basis for compensation.

The same kind of problem arises when one considers the possible genetic effects of radiation which have been demonstrated on many animal species. How one would attempt to determine whether or not an individual's radiation exposure might or might not have any effect on his subsequent generations it is difficult to see. If one could make such a determination it is still impossible to determine how one would compensate an individual for an injury allegedly done to someone who will not be in existence for many scores of years. One could raise the very serious question as to why the benefits for this imagined injury should be paid to one who has not been and will not be directly affected.

Indemnity Problems

In the workmen's compensation field in the United States the methods for providing payment for radiation injury are either already available or can be made available in the existing compensation system structure by relatively simple modification of present laws in a few states. In general, radiation injury can and should be treated as any other industrial accident or occupational disease. The consequences of radiation exposure include:—

1. Obvious injury to the exposed individual.
2. Long-time delayed effects resulting either from a single high level exposure or repeated low level exposures over many years.
3. Theoretical, unidentifiable and nebulous effects on the individual such as premature aging and shortening of life.
4. Genetic effects, based on statistical animal studies.

The first two of these will be identifiable as injury or disability to the exposed individual. The last two cannot, in the light of present knowledge, be identified or in any way causally connected to radiation exposure in an individual.

Acute Radiation Injury

If an employee is injured as a result of a single, high level exposure where obvious effects, such as burns, may occur, several problems may develop. First, the patient must be given immediate, adequate medical treatment. Second, compensation payments must be provided during the period of disability. Third, continuing medical observation must be provided for many years so that any chronic effects may be detected early and prompt medical treatment initiated. Fourth, in the event the exposure was sufficiently high to preclude further radiation exposure, the means must be available to provide for rehabilitation and retraining, if necessary.

Long-Time Delayed Effects

Since it has been well established that certain kinds of radiation over-exposures are capable of producing effects which may not develop until many years following an exposure, several serious problems have arisen in regard to indemnity payments in this area.

There will be difficulty in establishing a causal relationship between an injury of this type and either a much earlier exposure or a continuing series of low level exposures. It may well be necessary to establish, either under compensation laws specifically or by administrative action, criteria for relating injury or disability to long delayed effects. This problem is complicated by some difficulty of differential diagnosis since many of these effects can develop from causes other than radiation exposure. This can be made even more difficult if an individual has had substantial medical radiation in addition to industrial exposures.

Another difficulty will arise in cases which result from repeated exposures over a long period of time where there have been several employers and insurance carriers involved. The proration of liability among several such employers or carriers could be extremely knotty. If the compensation laws do not adequately provide for this contingency extremely costly investigation and litigation can result.

The other administrative problem of significance involved in providing equitable compensation for injury of this type is related to the timing of the reporting of injury. This is particularly difficult where there is a substantial gap between an

exposure and evidence of disability. A case in point would be a situation where an individual received a significant acute overexposure resulting in obvious injury, from which he recovered. If, after many years he develops an additional injury, which could be related to the original accident provision must be made to provide adequate protection for the second incident.

Finally, because of the current tendency to provide a life-time exposure limit for radiation workers it may be possible that an individual receiving such an exposure over a period of time would find himself barred from employment in the field for which he is trained even though there is no obvious injury. In such a case the questions relating to rehabilitation and re-training must be faced.

Theoretical Effects on Individuals

Experimental work on animals has indicated that some types of radiation exposures may produce premature aging or shortening of life. This can be demonstrated only on a statistical basis. There is no known way to establish proof of such effect on individuals. Inasmuch as our compensation system is based upon injury or disability to individuals, it is impossible to conceive of how any equitable arrangement can be made to cover this concept at the present time.

About the only possible approach to an evaluation of this factor would be to compare an individual's recorded radiation exposures with such guides as the recommendations of the National Committee on Radiation Protection. This is a very hazardous approach, since it is perfectly obvious from examination of the facts that the values which have been established by the NCRP are based upon inadequate evidence, particularly at low levels, and furthermore do not apply to these specific cases. Under no circumstances do we have any basis for utilizing standards as evidence of injury. This problem becomes more and more difficult as one deals with lower and lower radiation levels. As these levels approach background, larger and larger numbers of people receive such exposures and more and more potential claims for compensation could develop if based solely on whether or not a standard had been exceeded. At the present time, then, it can be stated that the evidence with regard to shortening of life and premature aging is far too nebulous to provide any basis for application to humans either within or outside the compensation system.

Genetic Effects

This problem is also completely outside the scope of our present concept of compensation since it involves no evidence of injury to the employee and there is no way of developing any evidence which would permit prediction of damage. Certainly there is no justice in having a compensation system which attempts to make payments in the present for something which might theoretically occur many generations in the future. This is an interesting area for philosophical discussion but is hardly an area for serious consideration in the workmen's compensation field.

Summary and Conclusion

In regard to the above-mentioned specific problems in the workmen's compensation field relating to the effects of radiation exposure, the existing concepts are perfectly capable of handling the problem of the obvious acute injury to the individual. It will also, to a certain degree, tend to take care of the difficulty associated with long-time delayed effects by eliminating the statute of limitations with regard to the reporting of the injury. As to the last two categories (namely, the nebulous premature aging or shortening of life and the completely indeterminate genetic effects resulting from radiation exposure to an individual) it is obviously impossible to attempt to meet these problems under any existing system of compensation. There is no basis for attempting to provide compensation payments for these theoretical or statistical consequences of radiation exposure. There is much which can be done, however, to assure an equitable solution to the problems related to radiation injury of industrial workers discussed above. This can be accomplished by setting up uniform provisions in workmen's compensation laws embodying the following principles which were set forth by St. Clair in his testimony on "Employee Radiation Hazards and Workmen's Compensation" (p. 427-428) before the Joint Committee on Atomic Energy of the Congress of the United States (March 10-19, 1959):

"1. Every injury due to exposure to radiation at work should be compensable.

"2. Any provision in the law that to be compensable disablement from an occupational disease must occur within a limited time after the last exposure or after cessation of employment by the employer against whom claim is made should not be applicable to radiation injury.

"3. The time within which a claimant must give notice or file claim should not begin to run until he knows or ought to know the nature of his disability and its relation to his employment.

"4. Such medical, hospital, and nursing care as are necessary to cure or relieve the injured worker of the effects of his injury should be provided without limit as to time or amount.

"5. The law should contain provisions necessary to insure that a worker suffering a radiation injury receives (a) the skilled medical care and special treatment required in such cases and (b), if necessary, such vocational rehabilitation as will fit him for another job.

"6. The last of several successive insurers of the same employer should be liable for all of the compensation due from that employer for a radiation injury caused by repeated exposures during each of the successive periods of coverage.

"7. The last employer and his insurance carrier, in a case where it is established that radiation injury is due to repeated exposures in the service of several successive employers, should be liable for all the compensation due the injured worker.

"8. The applicable labor and health laws, and regulations made pursuant thereto, should require every employer with a radiation hazard to observe proper safety precautions, to keep an accurate record of what employees are exposed to radiation, to preserve badges, films, and other information necessary for the safety of his employees and for the orderly handling of claims for compensation on account of radiation injury, and to give an employee, on termination of his employment or on request, a record of his radiation exposure."

These principles will provide a means of assuring medical and financial protection for injured employees. The implementation will require not only the proper legal framework, but also competent administration, for there are still so many gaps in our knowledge of radiation effects that no law can be written which will cover all possible contingencies.

Each jurisdiction must tailor its legislation and administrative procedures to meet its own specific problems, but basically if the eight principles set forth above are met, a sound basis for a program of indemnity for radiation injury can be established.

The Anatomy of Life Insurance*

JOHN O. TODD, C.L.U.
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JOHN O. TODD attained the C.L.U. classification in 1933, first qualified for the Million Dollar Round Table in 1935, and has qualified every year since then. He is a past chairman of M.D.R.T. and has been active for many years as a director or officer in C.L.U. and Association affairs. Mr. Todd is a graduate of Cornell and for several years has served on the faculties of C.L.U. institutes at the Universities of Connecticut, California and Wisconsin.

DID you ever try to explain your own profession to a seven or an eight-year-old in language that he or she would understand?

My first challenge in that direction came a good many years ago when my son was about that age, and he said to me one night at the dinner table, "Daddy, what is life insurance?"

You try and explain what you do, that you take for granted, in language that a child that age will understand. All of a sudden you begin to discover that you are not sure of all of those definitions.

Now it is not that I mean to compare you to seven or eight-year-olds; I just mean to point up the fact that our experiences are so divergent that it does make the task of trying to be interesting and valuable to you today somewhat difficult.

Well, what do we have in common? What can I bring to you that will put money into your pockets or the pockets of your clients?

Isn't there one area where we have identical problems, you and I and our clients?

We're all fairly substantial taxpayers. The better our clients are, the more taxes they have to pay, and the more clients we have that have to pay high taxes, the more taxes we have to pay ourselves.

Now I suspect that there is very little of your claim work that centers around the life insurance industry. I suspect that that is one of the reasons that life insurance has not appeared too frequently on your program.

After all, a man is either dead or alive. Oh, you may have a double indemnity problem at times: was it suicide or was it accidental death?

Occasionally, on TV at least, you may have a substituted body or some Bluebeard who insures his wife before he knocks her off, but I wonder if any of you can give me the answer to this one which I read about not so long ago.

A certain Mr. Jones had a $100,000 term policy which was reaching the end of its grace period. He had not paid the premiums and the policy expired at midnight, we will say, on July 7. Mr. Jones boarded the sleeper from New York to Boston at 9 o'clock, said good-night to the porter, retired to his drawing room and went to bed.

At 7 o'clock the next morning when the porter tried to call him, Mr. Jones was dead.

Question: Did he die before or after midnight?

Now if any of you has the answer to this very difficult case, I hope that you will report it to somebody because unless you are a detective writer I don't know how you are ever going to find an answer that is satisfactory to both sides.

It occurs to me that the most valuable thing that I can do today is to try to expose an idea or two—that's about the time we will have—as to how you might use life insurance as a means of improving the tax status of some of your well-to-do clients or even for your own estate structure. To do this requires, first, that we try to eliminate any difference of understanding by examining briefly the "anatomy of life insurance" and then having done so we can more readily consider how best to apply the instrument of life insurance in minimizing tax extravagance.

Now we all expect to, and we have a duty to pay our just share of taxes. However, I wonder if many of us realize what can happen today under our present tax law to a

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top-bracket taxpayer if he takes no steps to minimize the effect of corporate and personal income taxes followed by personal estate taxes?

Let me assume for a moment that you have a client who is a top-bracket taxpayer who operates a successful corporation which he owns.

Let me tell you what happens to the top $10,000 of his earnings, or any number of dollars, but let's use $10,000 for a given year in his corporate set-up.

First, his corporate tax takes $5200, doesn't it? That leaves $4800. Then it is paid as a dividend to him, and out of the $4800 he pays $4320 in personal tax. This leaves him $480.

Then he dies with the $480 in the savings bank as a part of his estate and the estate tax takes another $369.

So he is now down to $111 out of his top $10,000 of corporate earnings. That's 98.89 per cent. It is not quite as pure as Ivory Soap but he certainly is just as well cleaned.

But, you say, no one does it that way and that's my point: It is perfectly legitimate and perfectly proper not to do it in the most expensive way and yet if somebody were so naive as not to do anything except to declare the corporate earnings into dividends and keep them in his own accounts, this is exactly what would happen to him.

This is not a non-sequitur when I use the word "judo." All of us are familiar with judo and I think you would define it as I would. Judo is the use of the power of your adversary to throw him, isn't it?

And the power to tax is so enormous that the taxpayer must use "tax judo" to defend himself.

So let's first take a look at the anatomy of life insurance, or what I alternately call the I.Q. which stands for "investment quotient."

Let's look at this single sheet (Exhibit A) that is headed "The I.Q.," the "investment quotient," or "the anatomy of life insurance" as illustrated by $100,000 of life insurance, paid up at age 65, of a policy issued on a man aged 40.

I am using this merely as a typical age or a typical illustration. The figures vary but slightly or unimportantly in terms of demonstrating the principles as far as the age at issue is concerned.

In column 1 under the heading "Total Investment to Date," we discover that what we are doing is that over a period of 25 years, we are making an investment of $95,375, (that being the total figure at the bottom of column 1) in installments, the first of which is $3,815, and a similar installment which we propose to invest each year for the next twenty-five. And so we have as our cumulative investment to date at any given moment in column 1.

Now this is an unique investment in that, though we have not yet finished paying for it and it is under the installment plan, we are given the assurance that if at any time before we have completed making the investment we have occasion to use the principal that we are acquiring, either for collateral or for sale or disposition, we are given a stated-dollar-value in relation to where we stand at any given moment. Therefore, in column 2 is shown the estimated market or collateral value that is to be had by the living policyholder, if at any point along the way he has occasion to use this property which he is paying for for some other purpose. And here we discover that the market value reaches the total investment by the tenth year, and that by the 25th year the market value is some 25 or more per cent above what he has invested.

All during this period there has been the unique further factor involved, as demonstrated in column 3, which is the self-completion portion of the plan, for under the plan the insurance company is required to agree that in the event the original investor does not live in order to complete the investment that he proposes to make of approximately $95,000, a minimum of $100,000 will have been completed and will be available to his estate or the beneficiaries of his choice.

If by the end of 25 years he is still living, not only will he have completed his $95,000 investment as shown in column 1, which will have the market value of $121,000, as shown in column 2, but the insurance company is bound to provide $153,000 to his heirs in the event of his subsequent death. This is a fairly conventional and fairly orthodox illustration of the significance of the life insurance investment.

But now let's take a look and see what does it actually cost to do this, not the money that we put into the investment—you don't say when you buy a government bond that you have spent the money. What you have spent is the income that you might have gotten from the money if you had it some place else, and you measure the desirability of having that bond or any other

property on the basis of how the income cost compares with the income yield.

And so in columns 4 and 5, I show the cost of the money used for the premiums, that is, the investment in column 1 at 2-½ per cent.

Now why do I take so low a rate of interest? Is there anyone in this room that can borrow money or that is satisfied at this moment with a 2-½ per cent yield?

Well, you don't think so, but if you are in a 50 per cent tax bracket and you are paying 5 per cent for your money or getting a 5 per cent yield, then you are only getting 2-½ per cent and the cost of the money cannot be charged with more than it actually costs after the tax effect has been taken into account. And since one of the features of the insurance contract is that they will always lend you the money at 5 per cent and they must lend it to you without any conference with a vice-president or anyone else, just say "I want it," therefore, it is not proper to charge the cost of the money at more than it would cost you to get it, is it?

And, of course, we are talking now about successful people and successful people are in 50 per cent tax brackets, let's face it. This is what our problem is, or more.

And so we have in columns 4 and 5 the actual cost of the money that is used during this entire period of time and if we adjust our total investment by adding the cost of the money to the money itself, then we get the effect on net worth of having acquired this coverage during the period shown in columns 6 and 7. By net worth, we mean the portion of your money which is immobilized or unable to be used for some other purpose during this period.

Thus we see that at the 15th year we get to the peak, (even taking into account if the cost of money has been charged all the way) of $5,400. All during this period we have known that the net worth, as far as the replacement value of the earning power in the event of the death of the insured, has been increased or improved by an amount ranging from $97,000 to $29,000, as shown in column 7.

And this leads me to the I.Q. which is shown in columns 8 and 9.

The I.Q. is the "investment quotient," the percentage that the value available is to the investment that has been made to date. Here we see that in the first year even our living I.Q. is 39 per cent; in the 5th year, 86 per cent; in the 10th year, 99; and in the 25th year, 127 per cent; and for this temporary depreciation in the value of our investment in the event the insured has lived, we have acquired a 2647 per cent I.Q. in the event of death in the first year, a 555 per cent in the 5th year, 300 per cent in the 10th year and 160 per cent even if the insured has survived to 65 or beyond.

Now just quickly to finish this point, look at the lower left-hand corner where it says, "the status at the 25th year at age 65."

We now have a paid-up policy of $153,000. It started out to be a $100,000 policy. This is by the application of dividends, all having been left in to acquire paid up additions.

The investment to date has been $95,000, and so the excess of the estate value over the investment is $57,000.

If we have used somebody else's money or if we have charged your money with all the interest that it cost for the entire period, we will add $28,000 to our cost and the excess of our estate value, whenever death occurs after 65. Unfortunately, if death does not occur before 65, it of course must occur after. Whenever death occurs after 65 the death amount payable is $29,000 more than the total cost, and the total cost includes the interest to date.

But now, how interesting, we find ourselves then to be in the position where our annual tax-free dividends on the paid-up insurance amount to approximately the same as the cost or the yield on the entire investment regardless of how long it is left there. Thus, as you see, in this procedure our $29,000 becomes a net figure which is an improvement without having immobilized at any time more than $5,000, approximately, during the entire period.

There are two widely divergent ideas for the profitable use by your clients of this marvelous tool, and that is what it is. I am sorry to take so much time to take you through more figures, but there is such a difference of understanding as to what life insurance is that I felt that we had to come on to a common ground to understand what I am talking about when I refer to this kind of a tool.

One of these uses is a corporate use and the other is a personal use. Our time is too limited today to cover both in any detail, so I will only suggest why this illustration shows corporations that it pays them to own insurance in this form in substantial amounts on one or many key men.

Since, as you can see, it costs little or nothing of working capital to have had insur-

EXHIBIT A.

THE (I) NVESTMENT (Q) UOTIENT
or
THE ANATOMY OF LIFE INSURANCE

Illustrated by a $100,000 Life Paid Up at 65 Policy Issued on a Man Age 40

	(1)	(2)	(3)	(4)	(5)	(6)		(7)	(8)	(9)
						Effect on Net Worth After Adjusting for Cost of Money			The (I) nvestment (Q) uotient	
Year	Total Investment To Date	Estimated Market or Collateral Value	Estimated Total Estate Value	Cost of Money Used For Premiums at 2½% For Year	To Date	While Insured Lives		At Insured's Death	% of Market Value (Col. 2) To Investment (Col. 1)	% of Estate Value (Col. 3) To Investment (Col. 1)
1	$ 3,815	$ 1,490	$101,000	—	—	($2,325)	+	$97,185	39%	2,647%
2	7,630	5,070	102,100	$ 95	$ 95	(2,655)	+	94,375		
3	11,445	8,770	103,300	191	286	(2,961)	+	91,570		
4	15,260	12,580	104,600	286	572	(3,252)	+	88,768		
5	19,075	16,510	106,000	381	953	(3,518)	+	86,972	86%	555%
10	38,150	38,000	114,500	858	4,290	(4,440)	+	72,060	99.6%	300%
15	57,225	61,810	125,300	1,335	10,012	(5,427)	+	58,063	108%	218%
20	76,300	89,370	138,200	1,812	18,119	(5,049)	+	43,781	117%	181%
25	95,375	121,670	153,000	2,289	28,608	(2,313)	+	29,017	127.5%	160%

Status at 25th Year (Age 65)

Paid Up Estate Value	$153,000
Investment to date	95,375
Excess of Estate Value over Investment	57,625
Total Cost of Money Used To Date	28,608
Excess of Estate Value Over All Cost	29,017
Approximate Annual Tax Free Div.	2,300
Annual Yield on Investment To Date At 2½%	2,289

NOTE: Figures based upon standard rate of Northwestern Mutual of Milwaukee, and include estimated dividends based on the 1960 scale. Since dividends are not guaranteed, the values shown may actually prove to be greater or less, depending upon future experience. Dividends payable on Mutual Life Insurance policies are not considered taxable income.

ance on the lives of those who live, it just becomes good management not to take the loss without reimbursement to the corporation for those who do die. The only reason that corporate management may heretofore not have used life insurance, that I know of, is really because of the fact that it is human nature to think that there is nothnig that you get for nothing.

It is fair to assume that a large percentage of corporate key people are going to live. Management may think, "If we insure our people and they don't die, it will have cost us more for the people who live because we will lose the use of the money in our business than we will gain by insuring those who die."

Here you will see the way in which this tool operates from the corporation's point of view, when we are insuring a man for $100,000 or ten men for $1 million for the benefit of the corporation. A corporation is permanent. Men are mortals.

If the corporation is permanent, it must inevitably outlive the men, and since it is both the premium payer and the beneficiary, then doesn't it stand to reason that if it doesn't cost anything to have had the insurance for those who live, it costs quite a bit to let any of them die without having been the beneficiary of coverage to protect them?

Well, fascinating as are the possibilities for your corporate clients, suggested by this line of thought, I feel that it is important to discuss for our brief remaining time at least one idea for tax judo that you might do well with for some of your well-to-do personal clients.

A basic problem under the marital deduction provisions is to find a method by which life insurance can provide funds to pay estate taxes at each of the two deaths, the husband and wife, without adding to the taxable estate of either. And, for the benefit of any of you who do not work daily in this field, the marital deduction provision, as you know, is the provision that says, in effect, that half of the estate may be passed from the spouse that dies first to the other spouse without being taxable in the deceased spouse's estate.

This provision is equitable and works because of the fact that the second to die then picks up the half that he or she acquires and it becomes taxable in the second estate.

Therefore, the full impact of estate taxes is not felt until the second death and, therefore, ladies, even though your husband may have all of the property that you have between you in his name, the fact remains that your death is just as important as his, as far as the impact of the tax that is going to be paid, before the property that you have accumulated together, regardless of whose name it is in, passes on to your children.

This problem, then, of trying to provide funds through life insurance, (which is the orthodox and perhaps simplest method by which to provide the funds for estate taxes), is to avoid having the fund which is created for this purpose itself increase the taxable estate.

An orthodox solution for this problem might be for the husband to buy the insurance on the wife's life or the wife to buy it on the husband's life, but this puts the proceeds in the estate of the second to die. Therefore, though the tax may be postponed, it is still an additional tax.

Another orthodox solution is to give the policies to the children and pay the premiums as an annual gift. This is still a compromise because, if the children are minors or if there are minor grandchildren, there is no assurance that the proceeds will be available for tax purposes. The court may not allow the money to be used for this purpose if a minor has any right.

So, another step that is frequently followed is to create an irrevocable, unfunded, insurance trust and to pay premiums as an annual gift to the trust. The trouble here is that since such a trust would surely be a gift of a future interest, there is no annual exclusion available and, therefore, a gift tax return would have to be filed every year and, after the lifetime exemptions are used up, there would be an added tax in the form of a gift tax.

Well, let me suggest a less orthodox, and I might say, very-little-known procedure which you might find useful in one or two spots that you are thinking of at the moment.

Supposing that we have the spouse who holds the largest part of the estate, be it husband or wife, create an irrevocable funded term trust. A term trust is a trust which operates for a term of years.

I am only saying these simple things, asking the pardon of those who know exactly what I mean by the definition, so that we are sure that we are on the same ground.

We are talking of a term trust, let's say, that runs for 20 years. At the end of this time, the principal comes back to the donor or grantor of the trust. We have such

a trust for a period of 20 years to buy and pay the premiums for insurance on the life of the spouse with the smaller estate.

The insurance would become fully paid just before the term trust reverts to the donor for example, if we use a 20-pay life for a 20 year term.

At the end of the term, the principal would come back to the donor but the accumulated income represented largely by the paid-up insurance on the spouse will remain in trust, at least for the life of the insured and probably for the life of the child beneficiary.

And then, finally, and coincidentally, with the creation of the term trust, if we are dealing with people with really substantial incomes where income tax is a major problem, we may suggest that the donor also bring into being a family charitable foundation, that he or she create a foundation, a charitable institution, a corporation or a trust.

Now we have the tools. Let's see an example of what can be done with it. Let me show you by an illustration what the significance of this mechanism can be.

Let's assume that we have three children and that we are going to make a gift of $150,000 of principal for each of these children. If this were done in an irrevocable trust, that was to remain permanently, the gift would be $450,000, wouldn't it?

If it is a 20-year term trust, the present value of the gift, which is really a gift only of the income for 20 years, will be almost on the nose 50 per cent of the principal. So $225,000 is all that we have given by putting $450,000 into this 20-year term trust. And if we are paying our first gift tax, we will have a gift tax of about $35,000 to pay.

Into each trust, we also put $100,000 of 20-pay life at the estimated net average annual premium of about $4,500, we will say, on a 40-or 45-year-old man or woman, on the life of the spouse of the donor. If the trust earns a gross of 4 per cent, the trust has $150,000 in it, 4 per cent of $150,000 is $6,000. The trust will be a taxable entity because it is accumulating its income and the tax will not exceed 25 per cent; therefore, the tax will be $1500 and there will be $4500 left over with which to pay this premium.

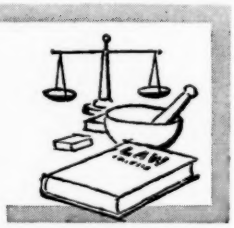
We now come to the reason for the charitable foundation. If we are dealing with really big incomes where we are trying to get some money back, cash in hand, then let's let the donor of the trust who is also the reversionary owner of the capital annually make a gift of that reversionary interest by assignment to the foundation in an amount sufficient to use up his 20 per cent of income annual exemption for charitable contribution, and thus, if we are in an 80 per cent tax bracket, every time we give away, (remember we had a $145,000 gift, it has a $225,000 remainder interest,) if we give it away over a period of the next ten years, we will have given away $225,000, and if we are in a 80 per cent tax bracket we will get 80 per cent of it back in income taxes. So here is a case in which by being a hero and making gifts to charity, we come out with more money than if we had kept it.

I realize that this is a by-pass and a detour from the main course of your usual deliberations but, in our practice, isn't it true that you have to often be prepared to be agile in many and diverse areas? Your clients and mine look to us with complete confidence for guidance in any area that promises benefit to them and, naturally we turn for this where we can get it.

Of course, I happen to be prejudiced because I believe that the life insurance vehicle is the most amazing financial vehicle ever conceived by the mind of man, and I believe that there is a life insurance solution for every financial problem that is better than any other.

Now, I don't expect you to go along with me that far but, in my 34 years of experience, every year brings me more testimony to strengthen that conviction. Whether you believe this at this moment or not, I am grateful to you for inviting me to your meeting and for your careful attention, and, if through our mutual study, we have done anything to help you, to help your clients or yourselves, then our mutual purpose has been accomplished.

OF LAW AND MEDICINE



Medicolegal subjects, the doctor-lawyer relationship, medical evidence, expert medical testimony, medical malpractice and its trends, and similar topics, will be presented in this department. The Journal will be pleased to have its readers submit articles of this type, either written by them or which may come to their attention.

The Clinical Use of Electroencephalography*

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ALTHOUGH there had been earlier suggestions that cerebral activity is associated with electrical alterations, the first reliable demonstration that alterations in electrical potential can be recorded from the brain was published by Hans Berger[1] in 1929. With his many publications in the early 1930's interest began to be shown in this phenomenon. In 1935 Gibbs[6] published (in collaboration with Davis and Lennox) his first paper on the electroencephalogram in epilepsy, and the next year Jasper[9] followed. In 1935 Foerster and Altenburger[5] noted the changes in the electroencephalogram and associated with intracranial tumors. In 1936 Walter,[13] and in 1938 Case and Bucy[3] confirmed these observations. Since then the interest in electroencephalography has steadily increased. Unfortunately there has been, at times, an overly enthusiastic clinical utilization of electroencephalography, and claims have been made as to its diagnostic values that are not in accord with scientific observations. It is important, therefore, that we make a dispassionate analysis of electroencephalography. What it is; what uses can be made of it; and, how it can be of assistance in clinical medicine, particularly in clinical neurology and neurological surgery.

By applying a number of electrodes to various parts of the human head, connecting them with suitable amplifiers and recording equipment, it is possible to record alterations in electrical potential between two different points. Commonly these electrodes are applied to the scalp overlying the cerebrum (although at times electrodes may be placed over the cerebellum, in the nasopharynx, on the ears or on the nose). The electrodes are usually flat, round metal discs about 1 cm. in diameter which are attached to the shaved scalp with a suitable adhesive. (Occasionally needle electrodes which can be inserted into the scalp have been used but in general these have been unsatisfactory.) By means of these electrodes variations in electrical potential between any two points can be recorded. Sometimes both points overlie one cerebral hemisphere; sometimes one is on one side and one on the other, and on other occasions comparisons may be made between a point over the cerebrum and a point on an ear or the nose, which the electroencephalographer hopes is "inactive" or "indifferent." It has been shown that the alterations in electrical potential thus recorded may result from changes in electrical potential within the cerebrum, particularly in the cerebral cortex. In fact it is in the hope of studying such changes within the cerebrum that the electroencephalogram is made. It is important, however, that the electroencephalographer be thoroughly familiar with all of the other sources that may produce changes in electrical potential between any two of his electrodes, and that may prove misleading in his interpretation. Among the more obvious of these are the action of the heart, showing an electrocardiogram in in the record; muscular activity of the fronto-occipitalis muscle or the muscles of

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the eyes or of mastication; or movement of an electrode in relation to the scalp; or such extraneous factors as electrical defects in the equipment, or the standard 60 cycle electrical current, or the electrical activity of unrelated electrical equipment in or near the hospital or laboratory. It is also important that the electroencephalographer recognize that the electroencephalographic equipment which is now quite standardized is providing him with an incomplete picture of the alterations in electrical potential occurring within the brain. This is true for two principal reasons—the equipment itself and the nature of the examination. The equipment has certain limitations built in it which restrict the frequency of alterations in potential that it is able to record. It is obvious that an ink-writing instrument writing on paper moving at the rate of 3 cm. per second (which is standard) cannot record the high frequencies which are present and which can be recorded, for instance, by a cathode ray oscillograph. The fact that no one knows the significance of these higher frequencies which the present equipment completely ignores is no evidence that these frequencies are less significant than those with which we are more familiar. But more important still is the nature of the entire examination. Alterations in electrical potential in the scalp are being recorded which it is hoped and believed are a reflection of the electrical activity within the cerebrum. At the very outset it must be obvious that recording from 16, 32 or 100 electrodes on the scalp can give but a very rough idea of the electrical activity within the millions of neurons and neuronal connections within the brain itself. In attempting to record the activity of the millions of units within the brain with a mere handful of recording electrodes we must be recording a summation of a large number of intracerebral units. If the intracerebral units were firing completely indiscriminately the alterations in electrical potential of half of them would cancel out the alterations in the other half and the electroencephalogram would be a perfectly flat line, i.e. we would record nothing. But, this complete silence of the electroencephalogram would not mean complete inactivity in the brain. In fact it might be consonant with intense activity. The fact that in the electroencephalogram we record something is evidence that at different times variable numbers of intracerebral units function synchronously, producing a sufficient preponderance of alteration of electrical potential in one direction to be recorded. In fact nervous activity within the brain is commonly associated with asynchronous neuronal activity, while inactivity permits a large number of neurons to assume a synchronous basic or inherent rhythm. Thus when the subject is lying relaxed with his eyes closed the basic alpha rhythm of 8 to 10 waves per second becomes prominent, but when the subject opens his eyes and looks about him, or even thinks of looking at objects while his eyes are still closed, the asynchronous and independent actions of the various neurons interfere with each other, the regular alpha rhythm disappears, and the electroencephalographic waves become irregular and their amplitude decreases. Similarly during sleep the electroencephalogram is characterized by slow waves of high amplitude and runs of very-regular more rapid waves called "sleep spindles," both of which are characteristic of synchronous activity of large numbers of cells. Or when the normal activity of areas of the brain is interfered with by pressure from a tumor, or by the edema and inflammation of an encephalitis, or by the relative ischemia of the acute stage of a cerebral thrombosis the electroencephalogram from that area is characterized by slow waves of high amplitude. (Cells that are rendered completely inactive by these or any other processes, of course, have no electrical activity and give rise to no waves.) Likewise, when any disease process seizes control of large areas of the cerebrum, thrusts aside all normal activity and occupies all units with a single activity, as with an epileptic attack, we can see the rapid, high voltage spikes of a grand mal seizure, or the slower but also regular wave and spike discharge of a petit mal attack.

The usable facts of electroencephalography are all empirically derived. It is capable at best of recording only the effects of gross lesions. The statement which has been made that it is the best available measurement of the physiological activity of the brain is completely without foundation. In this same connection it must be borne in mind that the electroencephalogram is incapable of demonstrating the absence or destruction of brain tissue. The electroencephalogram cannot disclose the absence of a lobe of the brain that has been removed surgically. It cannot demonstrate the functional inactivity of a frontal lobe that has been largely separated from the rest

of the brain by a lobotomy. Likewise, a quiescent cystic cavity that is not under increased pressure and that is not compressing or irritating the surrounding brain will give no evidence of its presence in the electroencephalogram. An area of brain rendered completely inactive by infarction gives no evidence of its presence in the electroencephalogram. In the acute stage an area infarction produced by cerebral embolism or thrombosis will so affect the neighboring brain as to give rise to a striking slow-wave focus; but, with the passage of time this slow-wave focus will disappear and the electroencephalogram will again become "normal." However, the "normal" electroencephalogram does not mean that the underlying brain has returned to normal, that the impairment of circulation was only temporary. Not at all. The return to "normal" of the electroencephalogram is most likely to mean that the edema and inflammatory reaction have subsided, while the ischemic brain has died, giving way to scar or cyst formation. (In this connection it should also be noted that Kempinsky[11] has shown in the experimental animal that in the acute stage infarction gives rise to a demarcation potential in the white matter between the infarcted tissue containing dying segments of axons separated from their cells of origin and the segments contained in the intact area on the other side of the boundary.)

"Normal" electroencephalograms may be misleading in many other ways. They may be unrevealing in the presence of a cerebral neoplasm, notably parasagittal meningiomas.[4] O'Leary[12] stated that infiltrating gliomas of the cerebrum are often difficult to recognize with the electroencephalogram. It has long been recognized that tumors of midline structures, of the third ventricle or in the posterior fossa commonly give rise to a misleading electroencephalographic picture.[4] A "normal" electroencephalogram is obtained in some 10 to 20 per cent of all cases of epilespy[10] and in approximately one-third of all adult epileptics. Subdural hematomas may be associated with a definitely abnormal electroencephalogram but the tracing is often entirely normal.

On the other hand, the electroencephalogram may be misleading in a positive as well as a negative way. About 10 per cent of individuals with no evidence of any kind of neurological abnormality have abnormal electroencephalograms.[7] [10] Usually these "abnormalities" are diffuse and of the type generally encountered in epileptics, rather than localized disturbances such as may be seen with tumors. However, even with tumors and other localized lesions misleading false localizing signs may be encountered. Thus a tumor of the right frontal lobe has been associated with an electroencephalogram that disclosed "abnormalities" localized to the opposite temporal lobe *only*. Jasper and Daly[10] stated that "slow waves in the contralateral frontal lobe have been observed in some cases of neoplasm or abscess of the posterior fossa." It must also be borne in mind that although a localized "slow-wave-focus" is typical of an intracranial neoplasm, the same type of electroencephalographic abnormality may occur with a localized infarct or hemorrhage, a traumatized area, an abscess or a localized area of encephalitis. Hoefer *et al.*[8] reported that in a study of 416 tumors of the cerebral hemispheres (i.e., excluding tumors of the diencephalon, midbrain, brain stem and cerebellum which are notoriously difficult to localize by electroencephalography) only 64 per cent were correctly localized. In another 9 per cent the side on which the tumor was located was correctly indicated. In 21.1 per cent there was no evidence of the presence of the tumor and in 5.3 per cent the localization was erroneous. In discussion of this paper Aird of California and Schwab of Boston reported that their experiences were similar.

Still another matter is of the greatest importance so far as the clinical use of electroencephalography is concerned. Relatively few clinicians rely upon their own interpretation of the tracings obtained from their patients. The study and interpretation of the electroencephalograms is commonly delegated to a specialist in that field. How reliable are such interpretations—how closely do several electroencephalographers agree with each other? Blum[2] has investigated that question. Standard electroencephalographic tracings were obtained from "ten routinely referred patients." Eight of these were subsequently shown to be suffering from disorders involving the central nervous system. The records were examined by five men trained in electroencephalography and with experience with the interpretation of the electroencephalograms varying from over 10 years in three to over 3 years in the least experienced. The percentage of complete agreement on pathology was 40, on localization was 30 and on both combined was only 10. I personally

have had experience with a case in which four electroencephalograms were made in three different laboratories. Each tracing was interpreted differently. One was said to indicate a lesion in one frontal lobe, one a lesion in the opposite temporal lobe, one was said to show a generalized dysrhythmia and one was said to be normal. It should be added that repeated neurological examinations disclose no evidence of any neurological disease and the history was not suggestive of any greater disturbance than a man seeking compensation for a trivial injury.

It is obvious that interpretation of the electroencephalogram is by no means easy and that there is a wide disagreement as to the significance of the tracings obtained among experienced electroencephalographers.

Although electroencephalography has the inadequacies that have been pointed out above, these can in the main be understood and proper allowance made for them. No method of examining patients is perfect but all, including electroencephalography, are useful and have their proper place. Far more serious than the limitations of the method is the misapplication of electroencephalography for purposes for which it should never be used. It is obvious that electroencephalography is but another laboratory procedure with many limitations. It is a highly specialized examination of a patient for a very short period of time—commonly not more than an hour. It can never be a complete examination in itself. It can never take the place of a careful history, a complete neurological and general physical examination, and an evaluation of all of the evidence available including roentgenograms, examinations of the blood and spinal fluid and special tests when indicated. It is but a small part of the examination of the patient. To diagnose or worse to prescribe for the patient on the basis of the electroencephalogram alone; or to testify in court regarding a question of injury to the brain on the basis of the electroencephalogram without having seen and examined the patient, without knowledge of the complete history is inexcusable. To attempt to classify the histological type of tumor present on the basis of the electroencephalogram alone is also inexcusable as well as impossible but it has been done and is indicative of the lack of critical judgment of some electroencephalographers. Such activities can only bring electroencephalography into disrepute.

Electroencephalography has a proper place in neurology and in medicine. It is not a substitute for any other form of examination. It should not be misapplied or misused. It is of little value in psychiatry, or with functional disorders, except in differential diagnosis. It will not help in the recognition of the "functional" psychoses, of mental retardation, psychoneurosis or migraine, but it may be of great assistance in identifying some of the brain tumors, encephalitic processes and subdural hematomas that masquerade as functional diseases.

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The Counterfeit Phrase of Neck Lash Injuries*

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An esteemed friend in Los Angeles, California, claims to be the guilty one who coined the phrase "whiplash injuries to the neck" in describing a series of eight cases of neck injury resulting from automobile accidents showing no actual pathology but having stubborn symptoms to relieve. This was in 1928 when he was too young to know better. *The counterfeit coinage of catchy phrases to describe a symptom complex with vague pathology seems to be a popular pastime in medicine.* There is "dyspepsia" which is an excellent example. The term covers most gastro-intestinal pathology including even emotional disturbances of the gastro-intestinal system. Another is "lumbago" with the recommended treatment of spas, ointments, and kidney pills. Then there were "slipped sacro-iliacs" and "slipped vertebrae" on which the cultists capitalized, often giving temporary relief to all types of sore back patients and chronic complainers. Now we have "slipped discs" which is a cover-all for the diagnosis of anything related to the spine. *None of these, however, compare with the "whiplash"* as a pay-off from a medical-legal standpoint, and there is nothing that can cure this distressing counterfeit phrase quicker than a substantial financial settlement.

The very idea of calling the mechanism of this unfortunate accidental trauma to the neck a "whiplash" is misleading. *There is no sound basis for it as a clinical entity or diagnosis.* The coinage of this term is so counterfeit that it casts a subversive and depraved influence, and constitutes a shield against a doctor's clinical observation and his integrity.

The mechanical phenomenon is in no way similar to the action of a whip's lash. A whip is a flexible object with a tapered end. There is no weight on the end, and it is directed against a surface to be struck when used. The neck or cervical region, on the other hand, is attached at its base to the trunk of the body; and at the distal end it supports the head, an object that weighs about 10 pounds. In either acceleration or deceleration in case of accident, the weight of the head is thrown to the limit of its regions and rebounds in the opposite direction, thus causing a variable degree of injury to the soft tissues and skeletal structure of the neck and perhaps of the cerebrum. This phenomena should in no way be confused with the crack of a tapered whip when the end is suddenly stopped against a surface by a twist of the wrist, and there is a cracking sound as the end of the whip is decelerated.[1]

Emphasis on this "whiplash" idea misguides the emotional make-up of a patient. Immediately after any injury to the neck, mental tension arises and the muscles of the cervical region go into spasm. Mobility may be limited. After all, this is a normal emotional response of the cervical region of most vertebrates. The cat, when alarmed, bristles its neck hair and reverses the normal hyper-extension cervical curve; the dog about to do battle does likewise; watch a prize fighter in the ring tense his bull neck as he drives his punches home.

The point is, there is no human mechanism that responds more readily to the tensions of emotions or injury than that of the cervical region. In fright the neck will freeze and straighten stiff. Hearing the news of a family illness, accident or tragedy, very often causes cervical tension and stiffness.

By planting the implication of "whiplash" in the patient's mind, perhaps a very innocent minor soft tissue pathology might stimulate vicious legal damage claims that may tend to compromise a physician's integrity in influencing an unreasonable settlement.

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[1]Some believe the cracking sound of a whip is caused by rapid acceleration of the tip which breaks the sound barrier. Others think this leaves a vacuum and a small clap of thunder is produced . . . *Ed.*

Medicolegal Aspects of Specific Sensitivity*

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THE scope of this article is limited primarily to specific sensitivities or allergic reactions of a dermatologic nature; however, much of what is said also would apply to other types of allergic reactions.

A specific sensitivity or allergic reaction in a particular person to a given substance may be regarded as a reaction of a type that would not usually occur in the average person exposed to the same substance for the same length of time and under the same conditions. In the absence of cross sensitivity to chemically related compounds, this reaction does not occur with the first or sensitizing exposure, but only at the time of an eliciting exposure occurring between five or seven days and 20 years after the initial sensitizing exposure. This implies an altered capacity to react. It must be distinguished from the reaction of primary irritation, largely unrelated to individual tolerance, which would be expected to occur in a high percentage of normal persons exposed to a given irritant under the same conditions for the same period.

The law has had much less difficulty in developing a definite legal approach to cases involving those individuals in whom primary irritation develops from contact with consumer goods or chemicals used in industry than it has had in finding a satisfactory solution to the legal problems arising in relation to specific sensitivities.

Several different broad areas of the law relate to specific sensitivities (table 1), and the legal issues involved differ in each of these areas; in some, a slow evolution is occurring. It is important in evaluating or giving testimony concerning specific sensitivities that the physician answer the questions pertinent to the legal issue involved.

Under the common law, tort actions may be brought on the theory of negligence or on the theory of breach of warranty. Negligence in this case implies conduct falling below the standard established by law for the protection of others against unreasonable risk of harm. Legal action in cases involving specific sensitivities may be brought if there has been (1) a failure to conform to the standard of conduct; (2) a reasonably close causal connection between the conduct and the resulting injury, such as negligence resulting in development of dermatitis; and (3) actual loss or damage to the interests of another. All these elements must be present. There is no limit regarding the amount for which a suit of this nature may be brought. Contributory negligence on the part of the complainant is recognized as a defense.

TABLE 1

AREAS OF LAW GOVERNING SPECIFIC SENSITIVITIES

COMMON LAW
Tort law
Negligence
Breach of warranty (representations made by the seller as to the character or quality of goods sold)
STATUTORY LAW (state and federal)
Breach of warranty (statutory tort)
Uniform Sales Act
Federal Railway Employer's Liability Act
Workmen's compensation acts

Action may be brought in cases of a breach of either express or implied warranty. The former refers to express representations as to the quality or character of goods on which the buyer relied in making the purchase and for which the seller was held strictly responsible. For example, if a seller recommends a specific product in answer to a buyer's request for a remedy for poison ivy or if a seller guarantees that a product will not cause a dermatologic reaction, he is expressly responsible for any effect the product may have on the purchaser. Breach of implied warranty has been recognized more recently. It appeared first in common law and is now governed by the Uniform Sales Act statute in effect in most of the states.

The buyer's reliance on the warranty is essential for liability. It is important to note in negligence actions that the causal relationship must be between the conduct of the vendor (wholesaler, retailer or manufacturer) or the employer and the resulting injury. It is not sufficient that the chemical or product itself be proved the causal

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agent. Proof of a causal relationship between the product and the injury is usually intertwined with proof concerning the causal relationship between the standard of conduct and the injury.

The characteristics of the three areas of statutory law primarily involved in negligence actions are outlined in table 2. It should be kept in mind that the workmen's compensation acts vary from state to state and that the physician evaluating the case must be aware of the exact provisions of the statute in his state. An allergic reaction involving the skin may be interpreted as an accident under the terms of the workmen's compensation act in one state and as an occupational disease under the terms of the act in another state. Certain workmen's compensation acts do not cover the occupational diseases adequately.

The legal issue of the standard of care involved is normally handled by the jury or the judge with the assistance of the attorneys. The physician must be prepared to evaluate that segment of causal relationship determining whether the chemical or product itself actually produced the injury. Table 3 shows a number of general criteria to be considered.[1] Tables 4, 5 and 6 list additional factors to be weighed, depending on whether the case being considered is covered by the workmen's compensation laws or by tort law.[1] [2]

The evaluation of a causal relationship is important in all areas involved between law and medicine in regard to specific sensitivity. However, additional factors of causation between the standard of care or the lack of it and the injury or specific sensitivity must be proved in common-law actions (including negligence or breach of warranty) and also under the Railway Employers' Liability Act. Such additional proof covering negligence is not necessary under the usual state workmen's compensation act.

In order to advise with regard to negligence in the use of certain substances, either in industrial settings or in relation to manufactured products for public consumption, one must acquire at least a "speaking" familiarity with the many available predictive procedures and with their accuracy and their limitations.[3] Procedures such as the Landsteiner-Jacobs guinea pig tests may be used initially to evaluate chemicals of unknown sensitizing capacity. These tests may be followed by tests on humans with the Schwartz-Peck prophetic technic, the Bruner repetitive patch technic, or the repeated insult technic of Draize and Shelanski.

TABLE 2

AREAS OF STATUTORY LAW COVERING SPECIFIC SENSITIVITIES

UNIFORM SALES ACT (covers two implied warranties of quality)

1. When goods are bought according to the description of a seller (whether or not he is the grower or manufacturer) who deals in goods of that description, there is an implied warranty that the goods are of merchantable quality.
2. When the buyer, expressly or by implication, makes known to the seller the particular purpose for which the goods are required and when it appears that the buyer relies on the skill or judgment of the seller (whether or not he is the grower or manufacturer), there is an implied warranty that the goods shall be reasonably fit for the intended purposes.

RAILWAY EMPLOYERS' LIABILITY ACT (federal statute covering an employee-employer relationship)

1. Liability depends on showing of employer's negligence.
2. Contributory negligence of employee is not an absolute defense but may serve to diminish amount of recovery.
3. Causal relationship between injury and negligence (not work) is required.
4. Employer is not an insurer of employee's safety.
5. The injury requirement is interpreted to cover occupational diseases, including dermatoses.
6. Amount of suit is unlimited.
7. Certain safety devices and procedures are required by statute.

WORKMEN'S COMPENSATION (covers employer-employee relationship; law differs in each state)

1. Employer is liable by statute without fault.
2. Negligence of employer need not be known or shown.
3. Principal element to be shown is one of causation between work and injury.
4. Fact issues are determined by the administrative body, and appeals may be made to the courts of law on matters of law only.
5. Monetary value of awards is outlined and limited by statute.
6. Occupational dermatoses in terms of specific sensitivity may fall under the terms of (1) a statute allowing full coverage for occupational disease, (2) a limited statutory schedule of specifically accepted diseases, or (3) a statute allowing coverage for accidents only.

TABLE 3

INFORMATION NECESSARY FOR EVALUATING MEDICO-LEGAL ASPECTS OF SPECIFIC SENSITIVITIES[1]

1. Date of patient's first contact with the article or substance under suspicion
2. Source of the article or substance
3. Date when eruption was first noticed
4. Parts of body first affected
5. Course of spread of eruption
6. Description of entire extent of eruption
7. History of any skin diseases which patient may have had previously
8. History of any skin or mucous membrane allergy in patient
9. Drugs, including laxatives and sedatives, used by patient
10. Drugs taken by patient prior to eruption
11. Date of any contact with poison ivy or other irritant plants prior to eruption
12. Duration of eruption
13. Date when use of suspected article was discontinued
14. Duration of eruption after use of article was discontinued.
15. Detailed description and results of any patch tests performed or reasons for not performing patch tests
16. Discription of how the chemical causing the dermatitis was determined
17. Summary of facts on which diagnosis was based
18. Description of treatment administered
19. Prognosis

At the present time, in order to maintain a successful tort suit based on either breach of warranty or negligence, it is generally necessary to show that the allergic plaintiff is one of an identifiable class or a sizable group of persons and is not merely a uniquely susceptible person in whom the reaction occurs due to the individual susceptibility rather than to the product. The present legal test is whether or not the manufacturer, by the exercise of *reasonable* care, would have known that a product might have been harmful to a normal person or to a sizable class of persons not normal. The result is that very few cases of specific sensitivity are successfully prosecuted.

Although the decisions are fairly uniform to date in holding against the allergic plaintiff, it is becoming apparent that the courts are experiencing some degree of dissatisfaction and discomfort with this result. This was evidenced by articles appearing in two law reviews.[4] [5] The current legal status of the allergic plaintiff is summarized nicely in the concurring special opinion of Judge Murrah in the case of Merrill v. Beaute Vues Corporation 235 Pacific 2nd 893, 26 ALR 963. Judge Murrah stated, "The difficulty lies in the failure of law to recognize the allergic or unusually susceptible plaintiff as [one of] a class of people to whom a manufacturer owes a legal duty to warn of potential dangers. Once the allergic plaintiff is recognized as one of a class of "some" people, the consequent legal duty becomes too plain for doubt.

"Science and medicine have now recognized the allergic and hypersensitive as a definite class of people, presenting physiological and biochemical problems arising out of the use [of] and contacts with products of advanced chemistry. If the law is to keep apace of social problems wrought by science and technology, it is high time for the courts also to recognize the allergic or unusually susceptible as members of a legally identifiable class to whom the law will extend its protection in warranty and in tort, and not as isolated individuals of whom the law takes no account."

The deciding opinion in this case was as follows: "We therefore have the question as to whether a manufacturer who places the product on the market, knowing that some unknown few, not in an identifiable class which could be effectively warned, may suffer allergic reactions or otherwise stated injuries not common to the ordinary or normal person, must respond in damages. Although there is authority to the contrary, we think that the prevailing and better rule is that the injury is caused by the allergy or unusual susceptibility of the person and not by the product."

It would seem that one of the specific missing links in these situations is the identification of the allergic plaintiff as one of a somewhat sizable class of people rather than as an isolated susceptible individual. If this can be accomplished, the manufacturer eventually will either have to modify his product description and advertising to provide notice or warning to the user about possible reactions or have to abandon the use of certain sensitizing chemicals. The responsible manufacturer also would be able to obtain and be guided by a more valid evaluation of the sensitizing capacity of certain chemicals in relation to the exposure volume of a given product. This process possibly might be considerably accelerated if some federal agency such as the Food and Drug Administration or United States Public Health Service would serve as a registry or clearing house for physicians for reporting cases of contact dermatitis due to specific sensitivity involving the use of manufactured products sold to the general

public or involving cases of specific industrial sensitivity reaction. This would serve to provide some statistical identification of the existence and the size of the groups of people involved. It is believed that the group of persons prone to allergic hypersensitivity-type skin reaction is of some size.[6]

TABLE 4

CRITERIA FOR DIAGNOSING OCCUPATIONAL DERMATOSES[2]*

1. Presence of a dermatosis in which the role of a major or contributing occupational causal factor has been previously established beyond a reasonable doubt
2. Known contact of patient with an agent which has previously produced similar changes in the skin
3. Correct time relationship between exposure to agent and onset of dermatosis, according to characteristics of the particular agent and the specific skin abnormality.
4. Site of onset of disease same as site of maximal exposure
5. Lesions consistent with those known to have followed the reputed exposure or trauma
6. Similar lesions known to have occurred previously in the same work
7. Presence of similar manifestations due to the same cause in patient's co-workers
8. Absence of exposure to an agent outside of occupation which could have been implicated
9. Evidence of previous attacks coming after exposure to the agent, followed by improvement and clearing after cessation of exposure
10. Corroboration of results of patch tests with history and findings of examination

*These criteria are difficult to apply (1) in cases in which an existing skin disease is aggravated by occupational factors, (2) when much time has elapsed between the development of the dermatosis and the examination, (3) when the disease has been overtreated, and (4) when complications of other dermatoses have intervened.

TABLE 5

POINTS THE PLAINTIFF SHOULD PROVE[1]*

1. Many other users of the suspected product had manifestations similar to those of the plaintiff.
2. The material causing the dermatosis was made with chemicals known to be sensitizers.
3. The suspected material contained new chemicals or chemicals not previously used in such products.
4. The manufacturer did not properly ascertain the skin-irritating properties of the product before offering it for sale.
5. The particular item was not properly processed according to the accepted custom of the trade.
6. Properly performed patch tests on the plaintiff and on controls showed that the suspected product is a primary irritant or sensitizer and the cause of the dermatosis.
7. The patient was not sensitive before the product was used.
8. The eruption appeared or became worse on use of the product.
9. The plaintiff was not allergic to any other substance which could have caused the dermatosis.

*Tort law.

TABLE 6

POINTS THE DEFENDANT SHOULD PROVE[2]*

1. Of thousands of users of the suspected product, the plaintiff was the only one affected.
2. The product contained no primary irritants or strong sensitizers.
3. The product contained no new chemicals or chemicals not previously used in such materials.
4. The product was made in the usual manner in which similar products are made and was approved by the trade.
5. Any new chemicals used were properly tested by recognized authorities and were found to be no more irritating than are chemicals commonly used for the same purpose.
6. Before it was placed on sale, the finished product was properly tested by recognized authorities on a sufficient number of people to show that it was no more irritating than are similar products.
7. The particular product used by the plaintiff did not differ from all similar products which had been sold and from which no trouble had resulted.
8. There was no cause-and-effect relationship between the product used and the dermatosis of the plaintiff; i.e., the eruption appeared, disappeared, became worse, or improved regardless of whether or not the product was used.

In making workmen's compensation reports, it would seem vital to remember to segregate the history given by the workman from the objective physical findings. This not only provides for more accurate appraisal of the problems involved but also aids the physician if the history provided him by the workman proves to be inaccurate. The physician could increase the accuracy of his reports by becoming familiar with his local industries and with the chemical problems encountered in them. He also should acquire a working contact point within the industry from which he can obtain an accurate history of work exposures, including secondary factors such as heat, maceration, friction, etc. The physician who approaches the problem in this fashion will be able not only to provide a more accurate report and thus aid in the administration of justice but also to achieve an earlier diagnosis and cure in the patient who has an industrial specific sensitivity. Such a procedure actually represents a time-saving device to the physician in his clinical practice. A much quicker clinical cure can be obtained in the patient with an industrial dermatosis if the physician can work with someone in management (a safety or personnel director) and relieve the source of exposure.

Prompt referral by safety and personnel directors, with quick identification and solution of the problem, will prevent disabilities resulting in lost time, preserve the safety record of the plant, maintain good employee morale, and create a satisfied and grateful patient, all of which will keep compensation claims at a minimum. In a sense, this might be called preventive legal medicine or preventive law.

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Legal Aspects of Coronary Disease*

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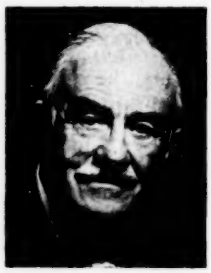
Felix, qui potuit rerum cognoscere causas. (Happy the man who has been able to understand the cause of things). Vergil, Georgics Bk. ii. 1.490.

THE PATIENT with coronary disease comes into court, or his decendents for him, mainly under 3 major conditions; (1) it is claimed that he has received a personal injury which caused or aggravated his heart disease; (2) his cardiac mischief has been produced or worsened by his employment (workmen's compensation); or (3) he is entitled to premature pension payments, governmental or private, by virtue of an occupational hazard to his heart.

In a case carried to the Supreme Court of Minnesota which was, however, not a cardiac problem, the court said "Since we as judges lay no claim to expertness in these matters [the etiology of cancer], we can add nothing to the discussion, nor can we be expected to resolve these conflicts which the medical profession itself has been unable to resolve. Notwithstanding this uncertainty, we think we are bound to treat the opinions of these doctors as something more than speculation and conjecture, which are but polite terms for unscientific guesswork."[1]

And as Larson says "Plainly, the heart cases will continue to be troublesome as long as some reach the appellate courts on a record in which the medical testimony is emphatically certain that effort and exertion have nothing whatever to do with coronary thrombosis, while most such cases are based on the opposite thought."[2]

Thus, the reason for litigation, in the cases of coronary disease, is referred to differences in opinion within the medical profession. The skepticism of lawyers about medical disagreements is illustrated by Lambert's belief that it is best to have adversaries in court rather than panels and "impartial" physicians, in these cases, since "the expert ism of today becomes the wasm of tomorrow." So litigation will go on, for, according to Justice Holmes "our ideal may be repose, but our destiny is effort."[3] It should be remembered that Holmes lived to the age of 94.



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There are influences, foreign to medical thinking, which color the legal aspects of the coronary problem, but which, none the less, physicians should understand. The first of these is the difference between the lawyer's and the doctor's definition of causation. This has been well discussed by Small.[4] The physician, indeed, must undergo an almost mystical revelation to accommodate his thinking to that of the legal profession as it relates to causation. "But," as Small says, "the lawyer and the doctor have so pontificated over simple words, so preened them and institutionalized them, that the layman thus put in the dark, is as wise as the lawyer and the doctor when each is confronted with the other's busywork." "The lawyer simply is not after the same cause as the doctor, and therefore cannot be expected to reach the same causal ends." This is perhaps even more striking in the case of workmen's compensation than in personal injury actions, because of what Horovitz rightly calls "the litigious phrase: 'arising out of' employment."[5]

The lawyer complains that the doctor has

*The Peter T. Bohan Lecture, delivered at the Alumni Day meeting of the University of Kansas Medical Alumni Association, Kansas City, Kansas, June 4, 1960. Reprinted by permission from October, 1960 CIRCULATION.

"difficulty in separating cause from etiology" whereas "lawyer—cause, whatever modifier be used, can have no meaning except that which it takes from the system, the system represented by the concept-term, Law. As that system is one of adjustment toward social harmony, certain policy considerations will inescapably control the adjustment process—policy considerations springing from social demands."[4]

Thus, "the defendant's part in the misfortune need not have been its sole cause, or even its principal cause, but only a cause of sufficient proportion, in the light of his conduct, to make it seem just for him to shoulder the cost."

It is in this phrase "policy considerations springing from social demands" that one sees the other chief influence affecting litigation of coronary heart disease. The physician attempts to have a scientific attitude toward causation, the lawyer's motivation is the socially desirable one of relieving the burdens of physical harm and economic tragedy. It is true that the physician at times descries in this yearning solicitude of the lawyer for humanity a certain element of crocodilian lacrimation when juries are notably generous on a contingent fee basis with attorneys' fees taking up to one third of the award; but how else could the indigent receive such skillful legal advice, is the lawyer's reply.

The tort, or personal injury cases, are of many sorts, from the fatal coronary thrombosis secondary to a shocking accident, to the exacerbation of angina from the mental stress of witnessing an altercation.

But it is not so difficult for the physician to attempt an assessment of the factors in such cases as it is for him to try to appreciate the change that has occurred in the purpose of workmen's compensation laws.

Even among lawyers there seems to be a difference of opinion about the genesis of these statutes—one side believing them to be the outgrowth of older common laws concerning personal injury, but the most vocal advocates asserting that workmen's compensation has nothing to do with "tort law," "scope of employment," "proximate causation," "foreseeability," "assumption of risk," or "blameworthiness"—all factors in personal injury actions. As Riesenfeld says, it "is fundamentally a branch of social insurance, designed to protect a segment of the population against sub-standard living conditions brought about by a typical hazard of modern society."[6]

Perhaps the most active defender of this concept of workmen's compensation is the National Association of Compensation Claims Attorneys, often called NACCA. Its journal is a rich source of material for tracing the historical development of the interpretation of the law as it relates to financial recompense for personal injury, and other forms of compensation. Similarly, Arthur Larson's "The Law of Workmen's Compensation"[2] is the constantly current loose-leaf reference work of the highest authority.

Workmen's compensation legislation started in Germany in 1884 as a part of state socialism to compensate the injured worker. Britain followed in 1897, Maryland had a Cooperative Accident Fund in 1902, Massachusetts set up its first commission to investigate the subject in 1904, the Federal Act was passed in 1908, in 1911 ten states passed Workmen's Compensation laws; finally in 1948 the last State, Mississippi, had joined the system.

The development of workmen's compensation differs in various countries. The British law originally defined the purpose in much the same way as do most of our present State statutes, namely, recompense for personal injury "by accident arising out of and in the course of employment." But it has become a "enterprise liability." "The enterprise of employment is responsible for harms occasioned by it." It is an entirely new social principle of "liability without fault." Or as Lloyd George is credited with expressing it, "The cost of the product should bear the blood of the workingman."[6]

Larson,[2 7] as United States Undersecretary of Labor, states the underlying philosophy as it applies in this country, at least in the vision of the welfare state, "Workmen's Compensation is one segment or department of the overall pattern of income-insurance, which includes unemployment insurance, sickness and disability insurance, and old age and survivors insurance." This concept is obvious in England, Australia, and New Zealand. The American system is unique in that it "is neither a branch of tort law nor social insurance of the British or Continental type," but has some of the characteristics of each. It is "social in philosophy" but "largely private in structure."

It will be seen that nonoccupational disability is the only interruption of employment not yet generally covered by insurance

in this country, and in this fact lies the growing modification of workmen's compensation rulings toward making it a type of over-all coverage for disability of any sort, and through this painful, Procrustean process chronic degenerative diseases, such as coronary artery disease, enter the field. The defense of the admission of these diseases as industrial accidents is that the people demand it; but this erosion of the concept of "industrial accident" has placed the medical profession in an untenable position.

How has this come about? By the process through which all law develops. As Roscoe Pound said, "The law grows by judicial application of reason to experience," and he points out that "the legislation of the social service state is, one might put it, changing the center of gravity of the law."[8]

Several very provocative decisions have almost succeeded in dominating legal precedent in cardiac, and especially coronary, cases. I say "almost," because decisions of appellate courts differ not only between states, but within the same state, or even within the same court. But certain features have become firmly established.

In the first place, in 1903 an interpretation was rendered by the British House of Lords of the term "by accident" to include the *result* as well as the *cause*.[2] Therefore "the 'by accident' requirement is now deemed satisfied in most jurisdictions either if the cause was of an accidental character or if the effect was the unexpected result of routine performance of the claimant's duties."

Also it is a legal principle that the employer "takes the employee as he finds him." That is to say, there is no provision for the "idiosyncratic individual" who may well be the subject of chronic disease at the time of employment, an argument of some weight in favor of pre-employment medical examinations.

There are 4 categories of employers liability for accident (Larson):[2]

1. The liability *usually* holds when something "lets go," such as hernia, cerebral hemorrhage, arterial or blood vessel rupture, ruptured aneurysm, apoplexy, etc.

2. In injury from generalized conditions during routine exertion the courts are less definite. These include coronary thrombosis, myocarditis, dilatation of the heart, and arteriosclerosis.

3. Routine exposure resulting in freezing or sunstroke is usually admitted.

4. The weakest category, so far as proof of accident is concerned, is routine exposure causing disease, such as pneumonia, rheumatism, nephritis, etc.

In the cardiac field a major legal tussle has taken place over the point as to whether or not an unusual degree of stress has occurred to precipitate the attack, usually angina, coronary occlusion, or acute congestive failure.

Georgia has carried its legal conclusions to the ultimate stage and its court has said "an accident arises out of employment when the required exertion producing the accident is too great for the man undertaking the work, whatever the degree of exertion or condition of health." In this State, heart failure has actually been held to be an accident even when the exertion was lighter than usual, as long as it was considered to have precipitated the attack.

This principle is accepted in New York, especially since the Masse case (1950), when it was held that "whether or not a particular event is an industrial accident" is to be determined, not by any legal definition but by "the common sense viewpoint of the average man."

That legal jurisdictions in the United States are not consistent in awarding compensation for disability from "general conditions," including heart disease, is seen by the fact that 19 award such compensation and 13 deny it.[2] It is admitted that there is a fear on the part of workmen's compensation boards and the courts that the heart cases will get out of control and that this sets some arbitrary boundaries for their decisions. They really do not want to compensate for deaths not actually caused in any substantial degree by employment. In general, there must be an unexpected result and there must be some exertion capable, medically, of causing collapse. Yet how liable to disputation is the classical pronouncement of Chief Justice Rugg of Massachusetts in 1914: "Acceleration of previously existing heart disease to a mortal end sooner than otherwise it would have come is an injury within the meaning of the Workmen's Compensation Act."[14 15]

The physician views some of these decisions with amazement. In one case a man fractured a heel bone in a fall and was said to have had pain and to have been anxious. He died 3 months later of a coronary thrombosis. Only 1 of 5 doctors who testified thought there was any connection, but the board chose this one's opinion and held for the plaintiff.

In another instance, a judgment was given for the plaintiff on the basis that a coronary thrombosis, allegedly due to lifting, lowered his "resistence" so that he died of cancer of the bladder.

Courts have found for the plaintiff when he suffered a heart attack during an altercation in which he was the aggressor. This element of contributory negligence has disappeared from workmen's compensation, an extreme example being the recovery of financial recompense by the heirs of a laundry man who was shot and killed by a testy husband who objected to the plaintiff regularly collecting his wife's amorous favors, as well as the laundry. It was held that he was on the job at the time and therefore entitled to workmen's compensation for an occupational hazard.[17]

Medical testimony may be completely ignored by the court, and it is true that appeal boards tend to uphold compensation boards even in the absence of "a single shred" of medical evidence of causal relation.[16]

A truck driver may work long hours without regular sleep and gain 40 pounds in weight, yet if he has a heart attack the decision may imply that his work alone was the cause of his death. "Presumption as to cause," says a Tennessee court, "should be resolved in favor of the employee."

As workmen's compensation expands it has entered an umbrageous area concerned with injury from emotional stress. In Massachusetts, this principle was held valid for the death of a motor vehicle inspector from a coronary attack occurring 1 or 2 hours after a supposedly stressful interview with the survivor of an accident. No testimony was submitted that the interview was emotionally disturbing. The Supreme Court merely decided it must have been![15]

No one would deny the influence of an acute emotional stress in precipitating an attack of angina, but the assumption of stress as the cause of atherosclerosis or hypertension is scientifically unwarranted and socially dangerous in its implications. Furthermore, coronary thrombosis to be attributed to an emotional episode must, it seems to me, show its onset by symptoms appearing at the time of the stimulus or in relation to some measurable alteration in heart rate, blood pressure, or other significant vital index, which continues unabated after the episode. No one has shown convincingly that local alterations in the coronary vessels (such as subintimal hemorrhage or rupture of atheromatous abscess), or hypercoagulability of the blood in these vessels, are related to either physical or mental stress.

In the United States Public Health Service study in Framingham, for example, about one third of the new attacks of clinical coronary disease were revealed by sudden, unexpected death in the course of the accustomed lives of the victims, and about 20 per cent of new coronary events were revealed by electrocardiographic evidence in the absence of any convincing history of cardiac pain.

There is one other compensation area into which coronary disease has entered by frontal attack. This is the disability pension system through the passage of so-called "heart laws" applying to certain categories of state employees. The Massachusetts act may serve as an example. It has removed opinion concerning causation from the medical field and placed it in the legislature, because this law states that if certain state employees develop heart disease or hypertension, it is to be presumed that these conditions are service connected, that is, arising from the character of their employment, and such select individuals are to be retired at any time with the special pension privileges enjoyed by other employees retired for accidental disabilities. The favored groups at present include firemen; policemen; employees of the Registry of Motor Vehicles who perform police duty; employees in the Department of Correction whose duties require supervision of prisoners, criminally insane or defective delinquents; crash crewmen; crash boatmen; fire controlmen or assistant fire controlmen at the Logan Airport.

Such presumptive legislation is another example of the erosion of the role of the physician in determining the relationship of an occupation to disease. It matters not that there is no significant evidence that these specific occupations are associated with premature or enhanced incidence of hypertension or coronary disease; it is only important that the voting of these groups be powerful. The members of the legislature wish also that their stressful devotion to lawmaking be recognized by inclusion of themselves under this law.

To some degree the medical profession is responsible for its sorry state. It has permitted medical testimony to be submitted in court which has been so far from reasonable that it has cast doubt upon all medical testimony. As a result, affirmations of no

scientific value are accepted on the same basis as those of high authority. As Hubert Smith phrased it, "Courts have plodded along, quite willing to recognize any holder of an M.D. degree as a universal expert on science. This naivete is surprising, for the same judge who rules a general practitioner competent on his qualifying or voir dire examination, will take the train for Mayo Clinic if he stands in need of specialized surgery!"[9] Courts and legislatures conclude that social pressures are such that they might as well decide causation by judicial or legislative fiat as to weigh conflicting medical opinion. Only occasionally does a court assert that mere possibility of causal relationship is not enough to sustain a finding.

In the Supreme Court of the State of Washington, for example, a judgment was ordered for the plaintiff's heirs because he was found dead 40 minutes after the end of his working day, during which he pulled levers. A physician had testified that "the fatal attack was precipitated by some physical activity which caused the clot, shown to be of long standing, to let loose."[18] The right coronary artery was shown at autopsy to be occluded by a thrombus. Is there any wonder that such evidence makes high court pronouncements about causation meaningless, as one from the Supreme Court of Idaho, "evidence of likelihood is enough"; especially, as Smith says, since "some medical witnesses are venturing opinions in Court which they would not assert before medical societies."

Lay bugaboos become enshrined and used as precedent, as in a Tennessee case, "The Court takes judicial notice that climbing of stairs is condemned by the medical profession as among the activities most harmful and dangerous to persons afflicted with heart trouble and arteriosclerosis." This is similar to the superstition about the danger to cardiac patients of raising the arms over the head.

Is this uneasy medicolegal situation likely to continue? Can any principles be promulgated concerning the relationship between overt coronary disease and the environmental influences subject to litigation?

It seems to me that the American system favors adversary action in the courts for an indefinite time. Certainly this is true in personal injury cases, since they must remain so highly individualized.

The American Heart Association has a Committee on Strain and Trauma which, for several years, has been investigating the medical and the legal aspects of the whole problem. As a member, I know the difficulties it faces, and the uncertainties of defining scientific proof. The precipitation of an attack of angina, fatal or not, can reasonably be shown at the time of an unusual event, but the relationship of such an event to the clinical pattern of coronary occlusion and myocardial infarction is much more obscure.

Blumgart[10] has stated the situation clearly: "Recognition of the causal relationship of effort to acute myocardial infarction should not lead the medical officer or physician to ascribe every attack of acute myocardial infarct to preceding effort. The occurrence of acute myocardial infarction in the foregoing cases during or immediately after strenuous effort clearly establishes a causal relationship. As with most diagnostic problems in medicine, the relation of effort to an attack of acute myocardial infarction in a particular patient may be certain, may be probable, suggestive or improbable or may be considered to be non-existent.

"The relation is considered definite if the following criteria are satisfied:

1. The development and increase of cardiac symptoms such as pain or substernal distress during or immediately following unusual effort.
2. Continuation of symptoms after cessation of effort.
3. The presence of the clinical signs and symptoms of acute myocardial infarction.
4. Development of the characteristic electrocardiographic pattern of acute anterior, posterior or lateral wall infarction."

Regan and Moritz[11] have also delimited the influence of trauma and stress on heart disease. In the editorial comment accompanying a reprint of this article in the book of Moritz and Helberg, the opinion is given that "If a medical witness is to be justified in attributing the disability for which compensation is claimed to some specific episode of trauma, he should have valid reasons for believing that the same degree or kind of disability would not have developed at the time that it did were it not for the specific traumatic event. This means that the witness should be able to defend the proposition that the particular manifesta-

tion of the disease for which compensation is claimed was not consistent with spontaneous occurrence and was, therefore, caused or contributed to by the effects of the trauma."

The much bolder concept that occupations as such, especially the so-called emotionally stressful ones, are responsibile for coronary artery atherosclerosis and disease is entirely lacking in proof. Regan and Moritz state, "In no circumstances can stress or injury be held accountable for coronary atherosclerosis." A great cult of stress is being developed in this country, aided by reports that, under conditions of emotional pressure, serum cholesterol rises and coronary troubles ensue. Gofman[12] has recently shown, however, that in one of these studies the rise in serum cholesterol was completely explicable on the basis of the admitted fact that the victims (accountants) under stress ate more.

Whether or not we are ready to admit overeating and physical inactivity to the category of industrial hazards is questionable, yet this would seem to be true, for political purposes, in the passage of "heart laws." However, there would appear, in fact, to be more evidence that the energetic stressful reactive life has protective value, but since it is impossible to titrate emotional stress the conclusions of "stress" studies are largely meaningless.

In the field of workmen's compensation one cannot disregard the pressure to include the degenerative diseases in compensable injuries, simply on the basis of social desires. Dawson has called this "a distinctively North American development." It is of interest, however, that there is a tendency for some of the labor unions at times to deny occupational relationship because the benefits under sickness disability insurance provided by some companies are greater than under workmen's compensation. Similarly, we have seen one pressure group, successful in obtaining special favors under the "heart law" of Massachusetts, now objecting to the extension of the law, to include further categories of State employees, for fear that the pension funds will be unable to bear the rapidly mounting expense.

It is to be hoped that some solution will be reached, since not only is the potential liability for coronary disease enormous in the American pattern of life, but the need for rehabilitation and employment of cardiac subjects and older workers demands a classification one way or another, either coronary disease is to be considered occupational and included in workmen's compensation or it should be provided for by some form of sickness disability insurance. One may present as many difficulties as the other, since sickness insurance is notoriously subject to abuse, but this sickness cash-benefit insurance exists (1951) in five states and under the Railroad Unemployment Insurance Act.

One senses a certain apprehension on the part of some lawyers that litigation may diminish if compensation cases are too readily adjudicated, but a further source of litigation has been suggested, namely, that even when workmen's compensation payments are granted to the employee he should also be allowed to return to his old common-law privilege of suing the employer in addition, if the latter has been negligent. I have seen no such solicitude for the employer when the worker is negligent.

The position of the physician in this whole picture is truly anomalous. He is still necessary for the process of the law but his testimony is accepted or rejected often quite cavalierly by the courts, and in relation to the social philosophy of the geographic area.

Of course the doctor who has treated the plaintiff is in a difficult situation and may be subject to the dichotomy of loyalty to his patient vis-à-vis his scientific conscience. There may be the desire to be a "good fellow," or even the knowledge that a favorable judgment would ensure his medical fee, or an unfavorable result, for want of his support, might lose him his patient.

On a less subjective level the medical man is forced to realize that in many cases he cannot be dogmatic about causation or aggravation. He can only offer his considered judgment and there is no question that a well-trained practitioner may know his patient better than the specialist. However, this does not excuse the practitioner or the expert from giving evidence so far from accepted scientific knowledge as to discredit the profession. It has even been suggested that a special committee of the state medical society review the recorded testimony of all physicians in court to determine their honesty or venality.

The Moreland Commission of New York[13] in 1957 studied the cardiac problem and from the answers of 398 internists and cardiovascular specialists they concluded, in part, that "work does not produce heart disease (93.9% against 1.5%); performance

of the same type of moderately heavy work without engaging in unusual evertion or strain has no injurious effect upon the heart. A myocardial infarction occurring during such work is not causally related to the employment (88.6% against 7.1%)."

This is at least highly competent medical opinion, but the difference in probative weight between medical judgment and judicial decision is illuminated by a Kansas case where it was held that compensation should be granted to the plaintiff since, "if his physical structure gives way under the stress of his usual labor, his death is an accident."

To the physician it appears more reasonable to allot a certain percentage of disability to an occupational aggravation of a chronic disease. This is the practice in California, Kentucky, and North Dakota. Above all, insistence upon an autopsy in death cases is, I believe, imperative.

Finally, the doctor is at a disadvantage in that he must maintain a scientific attitude—his greatest strength lies in this—but in Smith's phrase "the anvil of the law has always resounded to the striking iron of science" and "few members of the populace can have failed to hear the reverberating blows or to see the cascading sparks which fly from these impacts." He thinks that the lawyer, the doctor, and the man of science "may find themselves companion toilers on a more intricate pattern called 'social synthesis.' "[9]

What I wish to emphasize by this quotation is that the physician should have as much right as the lawyer to think in terms of this "social synthesis" within the rigorous confinement of scientific observation. The lawyer may rationalize his endeavors to prove that his client's occupation disabled him with a coronary thrombosis, and therefore that he should be paid, as contributing to the higher good, but the physician should also allow his broader viewpoint to prevail in denying the relationship, in the absence of reasonable evidence, with the hope that the social pattern would thereby be improved by lowering the barriers of the economic fear of employing cardiac subjects.

It does no good for the doctor to consider the lawyer ridiculous or nefarious, nor for the lawyer to think of the doctor in court as unsure, indefinite, or merely an instrument on which to play his tune.

When all is said and done, public opinion and social demands will determine the interpretations of the courts. The medical and legal professions stand as great symbols of free and individual enterprise. Both bid fair to lose status in a socialist polity but the physician especially is speeding the coming of this state if he fosters the establishment of a legal precedent that work is always an evil and must perforce accelerate chronic disease. He should instead stick to his scientific guns and let the evils of poverty, chronic nonoccupational disease, and misfortune be alleviated by other processes than by forcing him to accommodate his medical knowledge to the purpose of the social-service millennium.

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Whiplash Injury—End-Results In 88 Cases

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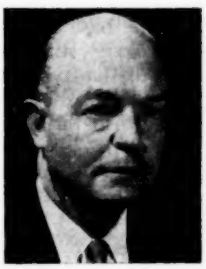

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ALTHOUGH the term "whiplash injury" is decried medically, it is one which has caught on and is unquestionably with us for a while despite its unfortunate emotional appeal. Many people injured in rear-end collisions have begun to seek this diagnosis, perhaps because their lawyers have found that a rebuttal is difficult and that it is often quite easy to secure a favorable settlement. Various studies have indicated that malingering and self-delusion have been only too frequently the real diagnosis.

The often quoted paper of Gotten[1] concerns a report of 100 patients interviewed after the settlement of litigation. He discovered that "many psychosomatic symptoms developed and were manifested in some way in 85 per cent of the cases." Frankel,[2] in referring to this group, states that it is impossible for him to believe that 85 per cent of any group could be conscious or unconscious malingerers and suggests that generalizations are dangerous and inaccurate. The Gotten paper, nevertheless, has caused the medical profession to look upon this injury with a suspicion which I have found to be justified.

This report considers 88 consecutive patients sent to me for evaluation prior to settlement of insurance claims. Eleven were referred for examination by attorneys for the plaintiff,[3] by their private physicians, and the remaining 74 by representatives of various insurance companies.

As in any type of injury, classification is a necessity prior to evaluation. In the classification outlined by Davis[3] all injuries to the neck are divided into 2 groups. One is the obvious, where the patient is unable to handle himself after the accident. This comprises such conditions as compression fractures, cord damage, paralysis, dislocation of the vertebrae, and obvious nerve injuries. There is no difficulty in the evaluation of such injuries, since, as Davis says, they are obvious. No cases in this series belong in this group.

It must be made clear at this time that many people who complain of whiplash injury do not have anything more than a temporary indisposition. They have no real injury to muscle, nerve, tendon or bone. Even though many of the cases in my series showed no organic findings, all were classified from the history into Davis' second, or obscure, group. To evaluate this "obscure group" one must correlate the physical, radiologic and neurologic abnormalities. Most of the patients show initial straightening of the spine in the lateral projection of X-ray films. Such straightening implies cervical sprain; however, it is possible for a patient to straighten his neck during the examination to produce the same radiologic picture. Neurologic testing on several occasions will, if consistent, furnish the data to classify these cases into the 7 syndromes of this group described by Davis:

1. Occipital, in which pain radiates up the neck to the occipital area (67 cases in this study).

2. The syndrome of the third and fourth cervical root, in which muscle spasm and neurologic abnormality may be present over the lateral angle of the neck (no cases in this study).

3. The syndrome of the fifth root, in which pain is present over the shoulder (2 cases).

4. The syndrome of the sixth root, in which pain is present over the radial side of the hand (9 cases).

5. The syndrome of the seventh root, in which the pain continues to the index and middle fingers (9 cases).

6. The precordial syndrome (no cases).

7. The syndrome of the long thoracic nerve (1 case).

Of the 88 cases reported, 15 patients had become free of symptoms prior to my examination, according to their statements. The findings were negative in this group. Forty-eight patients had various subjective symptoms without objective findings. These usually consisted of pain at the base of the neck, headaches of varying severity, and, in certain cases examined early, difficulty with abduction of the arms. One patient showed conversion anesthesia, and several patients had minimal diminution of pinprick sensations over various parts of the body, many of which were not consistent with anatomic nerve distribution.

Fourteen patients had subjective symptoms with objective findings. Of this group hypertrophic arthritis of a preexisting nature was present in 2 cases (in neither of which was there any evidence other than temporary aggravation of the arthritic process). Nine patients showed definite muscle spasm with limitation and restriction of cervical motion. Two patients had difficulty in abducting their upper extremities. There was 1 recently healed fracture of the first cervical vertebra, and this patient was the only patient with objective findings who had no symptoms 4 months after the injury. There was 1 patient with cervical symptoms arising from an alleged whiplash injury which cleared within 90 days, leaving a fairly definite lumbar herniated intervertabral disc syndrome which might have been present prior to the injury which led to this examination. One patient, who was free of objective findings but had moderate subjective symptoms, committed suicide about 3 months after examination but prior to financial settlement.

When findings are consistent throughout several examinations, and if there is straightening of the normal neck curvature, one can say from an objective standpoint that there is evidence of injury. With such organic abnormalities it is not difficult to arrive at the extent of the injury. An estimation of the extent and permanency of the impairment can then be made by evaluating the gravity of the injury, preexisting conditions,[4] other complications, and the emotional attitude of the injured.

There exists in the minds of most of the whiplash cases that I have examined the feeling that, even though the patients are not suffering at the time, they may suffer in the future. I have learned to ask all patients claiming whiplash injuries 2 important questions: (1) How long was it after the accident before you saw a doctor? and (2) How did you happen to go to this doctor? Only too frequently the patient states that he first saw a doctor a month or more after the injury and often he chose that particular physician at the suggestion of his lawyer.

After the elimination of definite nerve or bone injury, one can generalize enough to say that 90 per cent of patients with the so-called whiplash injuries seen in the average examiner's office can be accurately assessed as being able to make a complete and total recovery within 6 weeks if legal settlement can be quickly obtained. Cases in which preexisting organic abnormalities exist are more difficult to assess. There is also a group of injuries involving the Luschka joints which have been described recently and which must be considered.[2] One must make sure a traumatic arthritis is not present in this group and that the nerve roots and blood vessels in the vicinity of the injury show no evidence of abnormality. Thus, in effect, if one can rule out nerve injury, fracture, dislocation and arthritic changes, he may then be assured that permanent impairment of an organic nature will not ensue.

Since the conversion reactions are quite often seen in this injury the emotional aspects of these cases should be considered by all who have contact with these patients, especially the physician, the lawyer, and the insurance adjuster. We should be fully aware that we are dealing with patients who may be further injured, at least psychologically, by the least verbal indiscretion.

A very common finding in almost every case of the group showing no organic residuals is the attitude of doubt that the examiner will consider them to have been injured. Since these people show no visible evidence of injury, and since the collision may have done nothing more than mar the paint or chrome of the vehicle involved, the patients may feel that they have not received the sympathy they expected or deserved. As a result of this feeling of rejection they frequently exaggerate their symptoms. Many of the patients quickly and expertly remove Ace bandages and arm slings just prior to physical examination so that they may point out weak, painful, or anesthetic areas of their shoulders and extremities. These phenomena are manifestations of conscious or unconscious efforts to gain recompense they

consider to be deserved. It is this type of individual who can be further damaged by the flip attitude of the "doubting Thomas" who is dealing with the problem. One example to illustrate this phenomenon was a woman who developed partial hemianesthesia from scalp to toe as manifested by the loss of pain to pinprick and the inability to distinguish hot from cold stimuli. Her main symptom was the feeling that her left hand and arm had become numb and useless. Although she was able to use eating utensils she was forced to employ help to prepare food and clean her house. Interestingly enough, she lost her voice when her mother, who had been helping her, was taken to the hospital for treatment of a respiratory affliction. She recovered her voice when her son assumed the household duties her mother had previously performed. Some years prior to her present injury she had received a severe injury to the neck. A laminectomy had been performed and a divorce was obtained shortly thereafter. The neck injury apparently was the result of a beating by her former husband. According to the patient, she made a complete recovery shortly after the operation. The neurologic findings in the present injury extended to the exact midline of the body from forehead to hypogastrium with no overlap at any point. This was obviously a true conversion reaction. Just prior to trial this case was settled for $6,000, whereas $30,000 had been requested. No follow-up is available.

Summary

Eighty-eight patients with alleged whiplash injury were examined after maximum treatment benefit had been obtained and the patients were awaiting financial settlement. Eleven patients were referred by agents of the plaintiff and the remainder by agents for the defendant. No permanent impairment was predicted in any of these cases except for possible emotional or conversion reactions. Symptoms were due in large part to abnormal fear present in the minds of the patients as a result of having heard the dread term "whiplash injury" after the accident.

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